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ABSTRACT

This monograph discusses the Wallingford Wellness Project, a 3-year Administration on Aging model project designed to develop, demonstrate, and evaluate the effectiveness of health promotion and training with older adults. (The program in the Wallingford Senior Center offered classes focusing on exercise, nutrition, stress management, and environmental assertivenes.) Following an introduction that describes project objectives and discusses history of the project and its underlying rationale, six chapters authored by various members of the project team identify how the key program components were developed and operated. Topics covered include the participatory learning model, participant recruitment, the wellness self-help support group, transfer of program leadership and management to the community, evaluation research, and democratic team management. The eighth chapter contains written comments of Project graduates regarding aspirations, dreams, and hopes for a future of personal and societal well being. A selected annotated bibliography provides references on health promotion with older adults. Appendixes contain project materials, including program outlines, evaluation questionnaires, and job descriptions for personnel. (YLB)

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The Wallingford Wellness Project— An Innovative Health Promotion Program with Older Adults

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Stephanie FallCreek
and
Sue Bailey Stam, editors

Monograph No. 2—

Center for Social Welfare Research
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Stephanie FallCreek, Project Director

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photo by Lisa Christopherson

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Related Publications and Instructional Aides

INSTRUCTIONAL AIDES

A Healthy Old Age - A Sourcebook for Health Promotion with Older Adults. Prepared by Stephanie FallCreek and Molly Mettler, 1982. Curriculum guide and resources offered.

Health Promotion Educational Materials. Prepared by Wallingford Wellness Project staff. January 1982. Includes workbook materials for Environmental Assertiveness, Exercise, Nutrition and Stress Management.

Getting Older, Growing Healthy. Prepared by Andrew Garrison, Stephanie FallCreek, and Molly Mettler. An up-beat 16-minute slide of activities and interviews with Wallingford Wellness Project participants and staff and Health Promotion with the Elderly staff.

PUBLICATIONS

Organizational Process and Structure. June 1980.

Participant Recruitment Process I. June 1980.

Participant Recruitment Process II/Introductory Workshops. June 1981.

The above three informational booklets were prepared by the Wallingford Wellness Project staff.

Wallingford Wellness Project Followup Research Instrument (four-part interview schedule/questionnaire). Fall, 1981.

Lalonde, B., & FallCreek, S. Preliminary Evaluation of the Wallingford Wellness Project: A Model Health Promotion Program for the Elderly. Paper presented at the 34th Annual Scientific Meeting of the Gerontological Society of America and the 10th Annual Scientific and Educational Meeting of the Canadian Association on Gerontology, Toronto, Ontario, Canada, November 2-12, 1981.

The Wallingford Wellness Project Annotated Bibliography and References. Prepared by James Barrett-DeLong, Stephanie FallCreek and Mardell Witham. June 1982.

All of the above materials are available from the Center for Social Welfare Research, School of Social Work, University of Washington 98195.

Foreword

The Wallingford Wellness Project (WWP) was a research and demonstration project which began with the thinking of a social work visionary, Professor Art Farber. While he died halfway through this three-year project in the Fall of 1980, he helped to plant the seeds for an exceedingly fruitful endeavor. It all began with his recognition of the fragility of his own health and his discovery of the Peckham Experiment in England which was an innovative experiment in the 1930's focusing on health promotion within a family and community context. He tells part of the story in an article entitled, "The Peckham Experiment Revisited: Cultivating Health" (Health and Social Work, Vol. 1, No. 3, August 1976) as follows:

> In 1935, Pearse and Williamson, a British team of physicians-turned-human-etologists, offered the world an imaginative and practical perspective on the cultivation of health. The field test of their design was the Pioneer Health Center (PHC) in the London borough of Peckham. The effort was known as the Peckham Experiment, and it went beyond the treatment or prevention of illnesses to the promotion of healthy development. In contrast to the traditional medical emphasis on remedial measures, the aims at PHC were the preservation and cultivation of health. The family, not the individual, was the basic unit to be examined and treated, and the treatment centered on regular physical checkups. The program was open to all families who lived in a one-mile radius from the center--a group presumed to represent a fair cross-section of the national population.
>
> PHC was like a settlement house in that active participation in the social process of the center was an inherent part of improving health, independent of medical care. The building was thus designed to be as much a social and recreation center as a

medical facility. People who might have been intimidated by watching experts in any activity were encouraged to try new skills by the sight of other people doing them who were perhaps even less skilled than they. The center was like a family club in which people of all ages mingled freely. Young people were constantly presented with others who were a little older and more mature than they by whom they wanted to be accepted. This spurred them to grow and progess.

Art Farber was inspired by the prospects of health promotion and searched for ways to cultivate health. His search led to two pioneering works in the field of health promotion; namely, John C. McCamy and James Presley, Human Life Styling: Keeping Whole in the 20th Century (New York: Harper and Row, 1975) and John W. Farquhar The American Way of Life Need Not be Hazardous to Your Health (New York: W. W. Norton, 1978). McCamy and Farquhar are physicians who have emerged from their years of clinical practice to report that people need to learn how to take charge of their health. Both seek to translate their understanding of illness and wellness into a language and set of recommendations which promote overall health.

McCamy and Presley talk about the four pillars of health: nutrition, exercise, stress reduction, and ecology. These four major areas of individual life style require specific personal action to reduce individual risk of heart disease, stroke, and cancer or to ameliorate their impact once they occur. The major premise of McCamy's work which paved the foundation for the WWP is that the individual needs to understand the importance of lifestyle in promoting health and preventing illness and the necessity of personal commitments to action. For example, McCamy and Presley (1975: 55-56) developed checklists which the individual can use to assess her/his commitment to action in relationship to ecology. One such checklist encourages respondents to rate their efforts on community activities such as slowing down and stopping uncontrolled material growth, conserving and recycling resources, phasing out pollution, and stabilizing population. Another checklist relates to improving nutrition by eliminating refined carbohydrates, smoking, alcohol, saturated fats, coffee, tea, and increasing consumption of fresh fruits and vegetables. The third and fourth pillars of McCamy and Presley's lifestyling approach involve reducing stress and developing a personal exercise program.

A slightly different approach to health promotion was proposed by Farquhar who suggests that heart disease is linked to daily stress, sedentary living and middle-age spread, smoking, and eating habits. His approach is based on the premise that premature heart attack and stroke are preventable, that individuals need to assess their health habits associated with increased risk of contracting these diseases and then take action. He developed the following risk factor analysis (Farquhar, 1978: 41-42):

SIMPLIFIED SELF-SCORING TEST OF HEART ATTACK AND STROKE RISK

Risk Habit or Factor	Increasing Risk				
I. Smoking Cigarettes	None	Up to 9 per day	10-24 per day	25-34 per day	35 or more per day
SCORE	0	1	2	3	4
II. Body Weight	Ideal Weight	Up to 9 lbs. excess	10-19 lbs. excess	20-29 lbs. excess	30 lbs. or more excess
SCORE	0	1	2	3	4
III. Salt Intake	1/5 avg.	1/3 avg.	U.S.avg.	Above avg.	Far above average
or	hard to achieve; no added salt, no convenience foods	no use of salt at table spare use of high-salt foods	salt in cooking, some salt at table	frequent salt at table	frequent use of salty foods
Blood pressure upper reading (if known)	less than 110	110-129	130-139	140-149	150 or over
SCORE	0	1	2	3	4
IV. Saturated Fat and Cholesterol Intake	1/5 avg. almost total vegetarian;	1/3 avg. 2 meatless days/ week, no whole milk products,	1/2 avg. meat (mostly lean), eggs,	U.S. avg. meat, cheese, eggs,	Above avg. meat, cheese, eggs,
or	rare egg yolk, butterfat & lean meat	lean meat only	cheese 12 times/wk., nonfat milk only	whole milk 24 times/wk.	whole milk over 24 times/wk.
Blood Cholesterol Level (if known)	Less than 150	150-169	170-199	200-219	220 or over
SCORE	0	1	2	3	4

V.	Self-Rating of Physical Activity	Vigorous exercise 4 or more times/wk. 20 minutes each	Vigorous exercise 3 times/wk. 20 minutes each	Vigorous exercise 1 to 2 times/ wk.	U.S. avg. occasional exercise	Below avg. exercises rarely
	or					
	Walking Rating	Brisk walk. 5 times/wk. 45 min. each	Brisk walk. 3 times/wk. 30 min. each	Brisk walk. 2 times/wk. 30 min. each or Normal walk. 4½-6 miles daily	Normal walk. 2½-4½ miles daily	Normal walk. less than 2½ miles daily
	SCORE	0	1	2	3	4
VI.	Self-Rating of Stress & Tension	Rarely tense or anxious	Calmer than avg.	U.S. avg. Feel tense anxious 2-3 times/day	Quite tense Usually rushed	Extremely tense
	or					
		Yoga, meditation, or equivalent 20 min. 2 times/day	Feel tense about 3 times/wk.	Frequent anger or hurried feelings	Occasionally take tranquilizer	Take tranquilizer 5 times/wk. or more
	SCORE	0	1	2	3	4

Enter your total score here _____.

Notes: (1) Subtract 1 point if dietary fiber intake is high (almost all cereals whole grain, almost no sugar, and considerable fruit and vegetable intake). (2) If you are a female taking estrogen or birth control pills, add 1 point if score is 12 or below, 2 points if risk score is 13 or above (especially if you smoke, are overweight, have high blood pressure or high blood cholesterol). (3) Add 1 point for each 10 points of blood pressure above 150 and 1 point for each 30 points of cholesterol above 220. (4) Subtract 1 point if high density cholesterol level (the protective cholesterol fraction that increases with exercise) is greater than 50.

x

Interpretation:

Maximum points = 24

Zone	Score	
F	21-24	The probability of having a premature heart attack or stroke is about four to five times the U.S. average. Action is urgent. Try to drop four points within a month and three more points within six months.
E	17-20	Incidence of heart attack or stroke is about twice the U.S. average. Action is urgent. Try to drop four points within six months and continue reduction.
D	13-16	The U.S. average is 14. This is an uncomfortable and readily avoidabel zone. Careful planning can result in a five- to six-point reduction within a year.
C	9-12	The likelihood of having a heart attack or stroke is about one-half the U.S. average. This is a zone rather easily achieved by most people within a year if they are now in Zone D or E. Careful planning can result in a four- to six-point reduction within a year.
B	5-8	Incidence of heart attack or stroke about one-quarter of the U.S. average. This goal is achievable by many but often takes one or two years to reach.
A	0-4	Incidence of heart attack or stroke rates very low, averaging less than one-tenth the rate in the U.S. 35-65 age group. This goal requires diligent effort, considerable family support, and often takes three to four years to reach. Individuals in this range should be proud and gratified (and will often find themselves acting as models and teachers for the many who have not achieved this very low risk zone).

While the risk factor analysis identifies problem areas, specific steps are required for behavioral change. Farquhar suggests that the steps toward change include identifying the problem, building confidence and commitment to change, increasing awareness of behavior patterns, developing a personal plan of action, evaluating progress in terms of the action plan, and maintaining progress over time. The self-assessment rating for stress and tension below illustrates one step of this approach (Farquhar, 1978: 60-62):

SIMPLIFIED SELF-SCORING TEST FOR GAUGING STRESS AND TENSION LEVELS

(Circle the appropriate number in each item)

Behavior		Often	A few times a week	Rarely
1.	I feel tense, anxious, or have nervous indigestion.	2	1	0
2.	People at work/home make me feel tense.	2	1	0
3.	I eat/drink/smoke in response to tension.	2	1	0
4.	I have tension or migraine headaches, or pain in the neck or shoulders, or insomnia.	2	1	0
5.	I can't turn off my thoughts at night or on weekends long enough to feel relaxed and refreshed the next day.	2	1	0
6.	I find it difficult to concentrate on what I'm doing because of worrying about other things.	2	1	0
7.	I take tranquilizers (or other drugs) to relax.	2	1	0
8.	I have difficulty finding enough time to relax.	2	1	0
9.	Once I find the time, it is hard for me to relax.		Yes 1	No 0
10.	My workday is made up of many deadlines.		Yes 1	No 0

Maximum total score = 18. My total score _____.

Interpretation:

Zone	Score	Tension Level
A	14-18	Considerably above average
B	10-13	Above average
C	6-9	Average
D	3-5	Below average
E	0-2	Considerably below average

In addition to assessing and coping with stress, Farquhar underscores the importance of exercise, nutrition, controlling weight and eliminating smoking in promoting cardiovascular health. In all these areas of lifestyle change, Farquhar emphasizes the importance of identifying and involving social supports and engaging in contingency contracting.

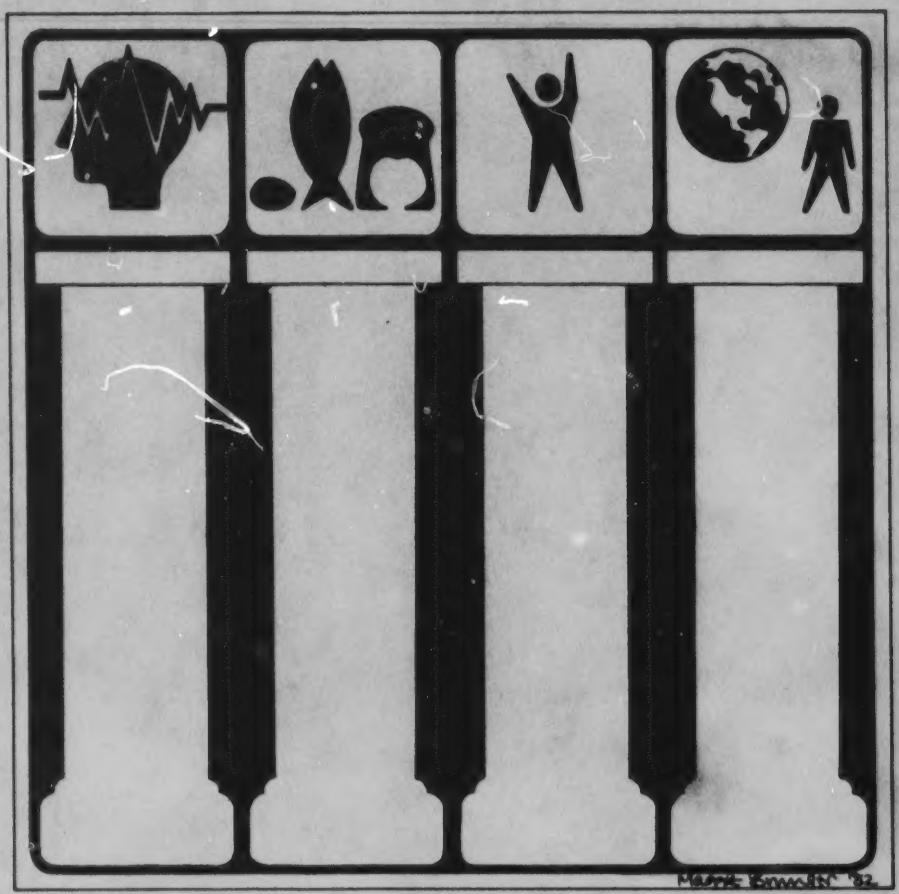
The ideas of McCamy and Farquhar, combined with the Peckham experience, clearly enhanced Art Farber's vision of wellness and provided the basis for developing a research and demonstration project which sought to apply an integrated approach to the needs of the elderly. This monograph highlights the experiences of staff and participants. Before and after Art's death, the Project staff played instrumental roles in keeping Art's vision alive. The experiences of this dedicated team of health promotion workers are reflected in the chapters of this monograph.

This monograph is dedicated to Art as a token of the appreciation of all of those involved in sharing his vision.

Michael J. Austin, Director
Center for Social Welfare Research

Herman Resnick, Co-Principal Investigator
Wallingford Wellness Project
Center for Social Welfare Research

May 1982



Introduction

Stephanie FallCreek

The overall goal of the demonstration period of the Wallingford Wellness Project (WWP) was to improve the health and wellbeing of project participants through education and training. This required that four basic objectives be accomplished:

1. Design an educational and training program that was appropriate for potential project participants.
2. Implement the program.
3. Evaluate the impact of the program on participants lives.
4. Ensure dissemination and perpetuation of the program.

Each of these objectives encompasses many activities ranging, for example, from program and research design, and securing community and agency support to recruiting participants and training program graduates to carry on the model. Further, in any community-based program, these activities rarely are accomplished separately or strictly sequentially. Rather they overlap, influence one another, and require ongoing attention and coordination. This is exemplified in the way the participatory staff management process influenced the development of the common-sense, participant responsive educational approach and the multifaceted research and evaluation strategy. Each chapter in this monograph addresses how one or more of the basic objectives was accomplished and each demonstrates the interdependence and integration of these in actual implementation.

This introduction provides a glimpse of some of the history of the project and its underlying rationale. A brief discussion of the program content that was presented gives a taste of what project participants actually learned and applied to their daily lives. The various chapters address the interests of program administrators, planners, service

providers, public officials concerned with health enhancing programs and policies for older persons, and advocates of wellness everywhere.

A NATIONAL PERSPECTIVE ON HEALTH PROMOTION

In 1979 the Surgeon General of the United States presented his report, Healthy People, to the nation. This document has become a manifesto for those committed to disease prevention and health promotion strategies as the foundation of a comprehensive health care system for this country. Public sanitation, immunization, and hygiene education programs have served to protect the public, prevent disease and enhance personal health in this country for the last century. What is new in health promotion programs is the increasing recognition that the present and future health and wellbeing of the population depends directly upon individual and collective action to improve personal and community health.

Most of the recent flurry of innovative and effective activities in disease prevention and health promotion have focused on middle aged and younger people. To date, people over 65 have received little attention in the "wellness revolution." Yet, this group, representing over 11% of the total population account for about 30% of all health care expenditures. This group includes the fastest growing segment of the population, those over 75, which also constitutes the age group most likely to consume the highest cost for health care services for the longest period of time. The economic incentives for disease prevention and health promotion activities with older persons thus are evident. It is also clear that a healthy lifestyle does make a positive difference in the health status of older as well as younger persons. In their study, Belloc and Breslow (1972), found that those over age 75 who reported following seven basic health-enhancing behaviors performed at the same health index rating as those people 30 years younger who followed few or none.

Perhaps even more significant, are the multiple incentives of social responsibility. Older persons are more likely than younger persons to suffer from one or more chronic diseases or other disabling conditions. As a consequence, almost half of Americans over 65 have had to limit their daily activities in some way. Further, about 20% of older people are limited in their ability to move about freely

(USDHEW, 1979). Health promotion programs can prevent or postpone the onset of many of these limitations for those who are not experiencing them.

For example, accidents are a leading cause of death in this age group as well as a major cause of temporary and long-term disability. The most common causes of accidental injury and/or death among older persons are falls, auto accidents, and fires. Accident prevention, though not specifically focused on in the WWP program, is an important element of health promotion programs with older persons. Individual accident prevention practices, such as seat belt usage, crime prevention techniques, and home safety assessments are among the many relatively simple and low cost accident prevention measures which can contribute directly to personal safety and wellbeing. Twenty-six percent of all pedestrian fatalities occur among older adults. In addition to individual approaches to reducing risk of these fatalities through vision and hearing screening and treatment activities, collective activity is also appropriate and feasible. Assisting groups of older persons to join together and identify particularly dangerous intersections and subsequently lobby for crossing lights or speed reductions is one example of how a comprehensive health promotion utilizes group strength and support to enhance the health and wellbeing of themselves and the larger community.

For those who already are experiencing limits in daily activity due to a health-related condition, health promotion programs can slow and sometimes stop or even reverse the deterioration process. For example, respiratory conditions such as emphysema, often directly associated with smoking behavior, place limits on the activities of many older persons. Smoking reduction and/or cessation can improve the situation dramatically for these persons. Another example, arthritis, affects about one in seven Americans and is often thought by older people to be an inevitable and uncontrollable aspect of aging. A health promotion program which includes information about the nature of arthritis, its warning signs and treatment, with learning self-care skills in exercise and relaxation to control the pain and progression of the disease can have a significant positive impact on the daily life of those who have the disease. Minimizing the impact of existing chronic diseases on daily life is a worthwhile goal in itself.

GUIDING PHILOSOPHIES

The oldest among us certainly have a right to enjoy the best possible health and hence the highest quality of life for all the years that they live. Further, older people in optimum health, living and working, participating in all aspects of community life constitute a national resource that we can ill afford to waste. Programs and policies which operate to enhance the health and wellbeing of older persons enhance the health of the nation.

Recognizing the social and economic imperatives for health promotion with older persons and responding to the Surgeon General's call to action, the Administration on Aging in 1979 funded the Wallingford Wellness Project as a demonstration and evaluation of a community-based model for improving the health of older people through education and training.

Philosophically, the WWP has its roots in the historical community of Peckham (a borough of London), England. This is reflected in many distinct aspects of the project. Two of the most important features are the intergenerational mix of participants and the emphasis on health behavior as it is manifest in daily life. The participants have ranged in age from 13 to 84. This integration of people of different ages is intentional, designed to bring people together to create a healthier community for people of all ages which includes people with different resources to share, different problems to solve, and different goals to achieve. The WWP focused on health and wellbeing in everyday life activities, not specifically on medical problems, conditions, or crises. The food people eat, the physical activities in which they engage, the inevitable, as well as the preventable, stresses and strains that must be managed, and the way the personal and community environment influences health are the core issues addressed in the training program. It is a model which incorporates the idea that over the lifetime the individual in her or his daily life can do more to maintain and improve health than any expert.

The approach used in the WWP also has its roots in social work practice. The highest possible value is placed upon empowerment of the participants. A wholistic perspective of the person in her/his living situation, which includes not only the individual, but also the family or significant others, the social environment, the social and health services system, and the physical environment is emphasized throughout the program. The active involvement

of paid and non-paid workers in creating living/working situations that enhance the personal and community wellbeing of participants was accomplished. And a spirit of sharing and cooperation guided the WWP staff in their relationships with other service providers evidenced through the dissemination of information and materials to national and local community and provider networks.

Fundamental social work values demonstrated in the WWP model were recognition and respect of the worth of each individual, the right of the individual to make her/his own choices, and the interdependence of individuals upon one another. Empowerment involved assisting participants in acquiring the information and skills they need to exercise maximum self-determination in order to achieve and maintain the changes in behaviors which improved their health and that of the community.

SHARING OUR EXPERIENCES

A brief description of the nature and level of our information dissemination activities provides strong evidence that interest in and commitment to comprehensive health promotion programs with older people flourishes and is more than the pipe dreams of a few academics, federal bureaucrats, or zealous health "nuts."

Sharing with others what was learned about health promotion with older persons was an ongoing activity. From the beginning, inquiries from around the country came to the project. What is your program? What do you teach? How do you recruit people? Do participants really change for the better? Who teaches the classes? Do you include disabled people? How much does it cost? Are you doing any research? These are among the most common questions we received, often accompanied by a request for educational materials.

Dissemination of project information materials and results has taken place in four ways. First, a considerable amount of local media coverage has been given to the project. Some of this was solicited and some was generated as a result of increased public awareness and interest about health promotion in general and the WWP specifically. Second, project staff have made numerous presentations at public and professional meetings in the Northwest and nationally. Third, many specific requests for written information have been

received and answered. Finally, the Administration on Aging in 1980 funded a national curriculum development and training project which used the WWP as the experimental base for the materials developed (FallCreek and Mettler, 1982).

In terms of the media, the Project has been highlighted in half a dozen local television interviews and documentaries, more than a dozen radio presentations, featured in both Seattle dailies, and in newsletters and magazines as well as in neighborhood papers. The distribution of written Project materials included: (1) informational brochures (6,000), (2) fact sheets (1000), (3) Health Promotion Educational Materials - participant workbooks (200, not including distribution to program participants), and (4) Project implementation packets (150 each). See page vi for a listing of these packets.

Staff and participants have made personal presentations to University groups, such as Long Term Care Gerontology Center and Institute on Aging seminars, local business groups (e.g., Grantmakers Forum, Breakthrough Associates), local professional associations (King County Nurses Associations) and national professional organizations (American Public Health Association, Gerontological Society, National Association of Social Workers, National Council on the Aging, and Western Gerontological Association). Staff have also taught several continuing education seminars and classes.

PROGRAM CONTENT

As described earlier, the choice of the four core content areas of the training programs was based primarily upon the writings of McCamy and Crosby (1975) and Farquhar (1978) as well as their identification in Healthy People (USDHEW, 1979) and the Alameda County Studies of Belloc and Breslow (1972) as those commonly associated with overall health and wellbeing. For example, high risk factors associated with coronary heart disease, the number one killer of all adults over 45, include diet, smoking, uncontrolled hypertension, overweight, lack of exercise and stress. The four pillars related to risk factors act synergistically to reinforce learning and changing behaviors in each specific area. Training materials were developed after review of the available literature and existing programs. As the program progressed, the needs and interests of participants and the experience of staff led to extensive refinement of the training materials. The basic program components included environmental assertiveness, exercise, nutrition, and stress management.

The environmental assertiveness component included assertiveness training, advocating for a safe and healthy environment, skill development in making and maintaining chosen behavior changes, and promoting self-responsibility for health behaviors. The activities in these classes were varied including lectures, field trips, reading and discussion, communication skills training, and group support building exercises. The basic material covered in the assertiveness and communications skills session included understanding the differences between assertive, nonassertive and aggressive behaviors, recognizing situations where assertive behavior would be useful, listening skills, and skills involved in giving and receiving feedback. Other environmental assertiveness class topics were determined by participants based upon the needs and interests of the group. These ranged from issues of personal security and safety like crime and accident prevention in the home to broad issues of community or national concerns like rent control and nuclear proliferation.

The exercise component emphasized three aspects of physical fitness: (1) increasing individual flexibility and strength, especially through stretching, (2) increasing cardiopulmonary fitness by engaging in aerobic activities, and (3) achieving a basic understanding of the physiological effects of exercise.

The classes offered participants the information and skills needed to assess personal fitness, practice a variety of stretching exercises, and explore special topics of interest to the group such as low back pain, yoga, and the physiology of aging. Building group support for individual change efforts and evaluating progress was an integral part of these sessions. Participants were requested to sign liability releases or (in some cases) obtain permission of their health care provider before participating in the exercise classes.

The nutrition component sought to enable participants to make educated choices about diet, and to encourage changes in unhealthy eating habits. Activities included discussion of selected readings using self-assessment and evaluation tools, preparing and tasting healthy foods, exchanging and modifying recipes and encouraging individual change efforts through group support. Information about and guidelines for food preparation relating to sugar, fat, salt, protein, complex carbohydrates, food additives, and food labeling constituted the basic foundation of these classes. Special topics like menu planning, eating out, and food preservation were also included. A potluck celebration concluded the nutrition course.

The fourth component on stress management sought to help participants learn healthy ways to manage stress in daily life by identifying stress patterns and stressors in their lives and by the use of relaxation techniques.

The activities included identifying general common sources of stress in the lives of participants and the learning of such stress management techniques as: shoulder and neck massage, deep breathing, counting breaths, progressive relaxation, and instant relaxation drill. In addition, special attention was given to the utilization of positive attitudes and self-statements to influence how the individual thinks, feels, acts in relation to stress. As in the other program components self-assessment tools and support groups were used to reinforce individual behavior change. Please refer to Appendices A-D for sample program outlines in each of the content areas. Appendix E illustrates the format and is taken from Health Promotion Educational Materials (1982) which contains the workbooks for all four program components.

CONCLUSION

The program content and delivery methods developed in the WWP reflect what we learned about responding to the health promotion needs and interests of older persons living in the community. Providing a program to share the tools of wellness with older persons is not vastly different from working to accomplish similar goals with any other age group. Rather, program design with any specific population group calls for differences in emphasis and adaptation of materials and techniques to recognize the increased or decreased incidence of specific conditions, risk factors, or living situations. Working with an older population requires the acknowledgement that older people bring to the learning-changing environment the accumulated habits, knowledge, and experiences of a lifetime. Perhaps, most significantly, however, effective program design for health promotion with older people demands that staff and participants alike examine critically the prevalent negative stereotypes of aging, which suggest a limited capacity for personal change and community contribution. A comprehensive participatory health promotion program, such as the WWP, provides many opportunities for both older and younger persons to explore the strengths and abilities of people to improve their health and discard the myths that limit us as individuals and as a society. Maximum wellness is not just for the super athletes, or those with

seemingly boundless physical and economic resources. Optimum wellness is recognizing that no matter what your current state of health, you can be doing your very best for yourself, making the most of what you have, striving for improvement, and sharing with those around you the challenge of creating a healthier environment for everyone.

In the chapters that follow, we have identified how the key program components developed and operated. Taken together these chapters demonstrate the process and progress of individuals and groups in the WWP as they moved toward achieving the best possible state of health and wellbeing for themselves and each other.

REFERENCES

Belloc, N., & Breslow, L. Relationships of physical health status and health practices. Preventive Medicine, 1972, 1, 409-421.

FallCreek, S., & Mettler, M. A healthy old age - A sourcebook for health promotion with older adults. Seattle, WA: Center for Social Welfare Research, School of Social Work, University of Washington, 1982.

Farquhar, J.W. The American way of life need not be hazardous to your health. New York, NY: W.W. Norton, 1978.

McCamy, J.C., & Presley, J. Human lifestyling: Keeping whole in the 20th century. New York, NY: Harper and Row, 1975.

USDHEW, Healthy People, The Surgeon General's Report on health promotion and disease prevention. Public Health Service, Office of the Assistant Secretary for Health and Surgeon General, Washington, D.C., 1979.

Wallingford Wellness Project staff. Health promotion educational materials. Seattle, WA: Center for Social Welfare Research, School of Social Work, University of Washington, January, 1982.

Participatory Learning Model

James Barrett-DeLong

> All human relations practitioners know...from their experience that knowing and believing and intending do not translate automatically into effective action. Knowledge in itself is not power; fine attitudes do not convert themselves easily into skillful doing; and objectives, no matter how worthy, do not carry within themselves the means of achievement. Given all the knowledge there is, the noblest intentions, and the best-laid plans, it is still true that if one is to know what to do, he must learn to do (Schwartz, 1979).

The participatory learning model (PLM) reflects the spirit of the staff and the intent of the Wallingford Wellness Project (WWP) proposal. It is characterized by flexibility, openness to change, spontaniety, responsiveness to participant needs, cooperation, and a sense of community. The demonstration grant was to develop and evaluate an educational format for teaching older people exercise, nutrition, stress management, and self-responsibility for health. The educational model developed represents the integration of the Peckham spirit, the values of wellness, and social work groupwork techniques. It was developed and refined over the life of the project using feedback from participants and staff. The participants thus helped us to learn what to do and how to do it better.

This chapter focuses on the participatory aspects of this educational model. It describes the process of teaching intergenerational health promotion classes, provides a rationale for the role of social work in health promotion, presents the theory and practice of the PLM, and suggests implications for future health promotion programming.

Traditionally, social workers have worked with individuals and groups within a social situation to empower them to act on their own behalf. Social work expertise involves the use of an enabling process which is designed to create

conditions that have been found to help individuals to develop their capacity for changing their life situation (Maier, 1976). This process is critical to the WWP educational model for health promotion. Schwartz's (1979) observation that knowing does not always translate into effective action is particularly relevant to health promotion. For example, a 1978 nationwide health maintenance survey found that:

- Fully 67% of Americans recognize that they would be healthier if they ate more of some foods and less of others.
- Fully 70% of smokers know that smoking increases their chances of getting cancer and yet they still smoke.
- Two out of every five Americans believe that they ought to exercise more than they do.

The survey concluded that the most effective program to influence health behaviors and habits "will probably use a variety of different methods and a mix of different media to increase knowledge, influence motivation, and change behavior" (Harris, 1978).

The primary challenge of health promotion programs is to assist people to manage the complex task of taking responsibility for their health. This calls for more than a cognitive understanding of how to act. An understanding of the interplay among the major dimensions of human functioning, mainly cognitive, affective, and behavioral, is required in order to help people as they undertake significant changes in their lives. The social work repertoire of knowledge and skills for intervening to further an individual's total functioning is based on the importance of feelings and attitudes in mobilizing the emotional and intellectual learning processes. An understanding of the complex interplay of behavior, emotion and intellect was used by the WWP staff to design a balance of activities, exercises, practice, presentations, and discussions to promote maximum learning among participants.

VALUES UNDERLYING THE EDUCATIONAL MODEL

The values underlying this educational model also served to guide our personal actions and our management structure and process. These dominant value included a desire to empower both participants and staff, in order to increase our individual and collective capacity and skills to develop healthier lifestyles, to effectively shape our lives. Key values reflected in the participatory learning model include:

1. Self-responsibility for health: To improve health significantly, a person must see her/his own actions as central to personal health and wellbeing.

2. Participants' self-determination: People of every age have the capacity and the right to make meaningful choices about their lives.

3. Acting on one's values: By action, individuals experience that they can have a positive effect on their personal health and that of environment.

4. Equality of staff and participants: To foster true dialogue, one must first be committed to equality, to the abolition of privilege, and to nonelitist forms of leadership.

5. Establishing and maintaining communication and community: Implied are collaboration, cooperation, interdependence, and the development of relationships supportive of positive lifestyle change.

THE BASIS OF THE PLM

The participatory learning model is based on Dewey's assumption that people learn best when they share in the development of educational content and take an active role in shaping their educational experience to their own needs. Staff and participants developed class and course agendas in the first few meetings in order to build this learning partnership. This adult education model assumes that people are capable of directing their own learning activities in an autonomous manner (Oberman, 1978).

Participant feedback and interaction involved learning and practicing communication skills to become more aware of the effects of participant behavior upon others as well as the influence of the behavior of others on the participants. The PLM sought to direct participant attention to the group atmosphere and its influence on individual behavior rather than on individual emotions. An understanding of group dynamics was utilized to develop and strengthen group norms for healthy behavior changes. Group conformity can contribute to accomplishing group goals as long as it does not limit individual creativity and exploration. Specially designed group activities were implemented to strengthen personal decision making.

In addition to participant feedback and interaction, the following procedures were used to enhance the behavior

training component of the program: baseline measurement, setting individual goals for behavioral change, role playing, practice, recording behavioral changes, skill reinforcement, evaluation, troubleshooting, and reassessment of goals. The group setting provided the opportunity for modeling, shaping, and reinforcing the behavior of both participants and facilitators. For example, these techniques were applied in the assertiveness training component where participants were taught to articulate their wants and needs, to voice their opinions, to share their criticisms in a constructive manner, to offer praise, to provide support, and to listen carefully.

Counseling theories indicate that natural curiosity and the urge to learn can be dampened by distressing learning experiences. Therefore, it was important to provide a learning environment where individual thoughts and feelings were heard and respected. For maximum learning to occur, the material presented must have a reference point in the learner's present knowledge, and be given in appropriate amounts (too little will bore, too much will overload). When given appropriate information and a supportive atmosphere to explore the meaning of that information in their lives, people will make the best choices possible for themselves.

Another counseling principle suggests that something can be learned from each action taken (or from one's difficulty in taking any action). For example, if someone computes their exercise heart rate incorrectly in class, the facilitator might review the computation process, communicate an understanding of the person's efforts, and then review the correct process. This approach maintains and even supports self-esteem in contrast to ignoring an individual's thinking process or telling people that they were wrong.

Project staff used the philosophy of participatory learning from their first contact with potential participants. Introductory meetings to recruit participants offered a balance of information about the project and audience get-acquainted activites. Participants described their personal approaches to health, and engaged in stretching exercises and tasting healthy snacks. Everyone was encouraged to bring to the classes their knowledge, skills, and resources about staying healthy as well as an interest in learning from each other.

The weekly three-hour classes met over 24-, 21-, and 14-week periods which were modified as the program content was refined and organizational resources and constraints changed. Each week, participants spent equal time in an

environmental assertiveness section and either a stress management, nutrition, or exercise section. There was usually a break during the approximately 85-minute-long sections, and always a break between the two sections. Over the life of the project, the staff developed a standard agenda form that made planning the class sessions both thorough and efficient while allowing flexibility in class execution (see Appendix F).

Project classes used a variety of means to promote behavioral change. Classes provided for: (1) identifying current behaviors; (2) transmitting knowledge; (3) designing individualized behavior change strategies; (4) experimenting with new behaviors; (5) networking and securing ongoing support; and (6) sharing experiences and insights, difficulties and achievements.

1. IDENTIFYING CURRENT BEHAVIORS. In the first classes, participants individually assessed their behaviors in a given content area using either the assertiveness response survey, daily stress and tension log, the physical activity survey, or a daily diet survey (see Appendices G-J). This baseline assessment identified present behaviors and skills, and provided a base from which to build and refine skills and behaviors. In the stress management section, staff would list on newsprint all the stress management activities which the participants were currently using. Invariably these lists were impressive in size and variety. Participants who thought they knew very little about managing stress often acquired a new appreciation of their resourcefulness as well as new stress management techniques. Their own resources could thereafter be mobilized more consciously and systematically to deal with stress.

In the first few sessions considerable time was spent getting acquainted, developing trust, and creating an accepting and supportive atmosphere. Exercises were done in dyads and triads so that each class member initially became familiar with at least a few people. Exploratory group discussions probed the participants interests, expectations and hopes for the classes. Topics for the content areas were planned by each group, based on their interests, staff and group resources, and project goals.

2. TRANSMISSION OF KNOWLEDGE. Both participants and staff expected to share useful health promotion information. Staff did not presume to have all the answers. Questions were often referred back to the group for discussion and consideration. Resources were identified that could

provide more information on complex or controversial issues. By identifying staff as learners along with the participants and looking to participants as teachers as well as learners, staff promoted greater participant involvement and motivation.

The chronological ages of staff and participants spanned eight decades. Learning with people of diverse ages and backgrounds requires being open to understanding different language, experiences, and perceptions of the world and accepting them while not necessarily agreeing. We discovered by trial and error the meaning of different words and symbols for individual participants. For example, one participant showed no spark of understanding when "mental sets" and "positive affirmations" were explained to her until she lit up and offered, "Oh yes, you mean like Norman Vincent Peale and the power of positive thinking." Then we were communicating.

The health promotion and education workbooks provided the basic material for the classes (Wallingford Wellness Project staff, 1982.) There were supplemental handouts on specific topics, and participants were referred to the project library for more in-depth information.

3. DESIGNING BEHAVIOR CHANGE STRATEGIES. Participants were taught how to use a self-contract form known as the Affirmation of Health (Figure 1) to articulate their goals, to take the action steps needed to reach those goals, and to gain support and reinforcement during the process. These forms were filled out by individuals who often worked in groups of two to four with other class members and staff. Sometimes staff asked those participants who were willing, to share their upcoming plans and thereby increase their motivation to enact the plan. Each week, in a reportback discussion, participants shared the steps they had taken toward their goals. These discussion sessions became important times to identify difficulties, encourage participants with low motivation, and, through sharing successes, build the self esteem of participants.

4. EXPERIMENTING WITH NEW BEHAVIORS. The classes offered a safe and supportive environment to learn and test out new behaviors. The participants explored a wide range of activities such as role playing assertive skills, exercising one's body in new ways, cooking and tasting new recipes, trading shoulder and neck massages, "bragging" about healthy behaviors, and offering constructive criticism to the staff.

FIGURE 1

AFFIRMATION OF HEALTH

NAME _____

1. The major goal I want to accomplish in the next ____ weeks is:

2. How I plan to accomplish this goal is:

WEEK	ACTIVITY	WHERE	WHEN	TIMES PER WEEK	WITH WHOM

3. In order to help me follow through with my activity, I will:

_____ Keep a journal of my thoughts, feelings, and reactions.

_____ Keep records on daily activities survey or log.

_____ Invite a friend or family member to work with me in my effort to change. The way this person will help me is _____

_____

_____ Invite someone from the class to work with me in my effort to change. The way this person will help me is _____

_____

_____ Reward myself by _____

_____

5. NETWORKING AND SECURING ONGOING SUPPORT. Staff assisted participants in developing supportive relationships in and out of the class. A majority of the participants had been raised with a strong belief in self-sufficiency which sometimes made it difficult for them to ask for or accept help from anyone. Participants learned to ask for help by recognizing the importance of letting someone help them, and thereby giving something of value--the feeling of being needed. Every person is both a giver and a receiver. People generally appreciate being told how they can help, instead of guessing or feeling inhibited by apprehensiveness.

Staff supported participants in their efforts to change while simultaneously striving to strengthen participants' internal sense of faith in the validity of their own pacing, decision making ability, and judgments. The desire for change came from within the participants. The staff learned that when participants stopped making changes in their lives, grew quieter in class, skipped class or left class feeling drained and discouraged, it was often the case that they were feeling too much pressure to achieve wellness goals. When staff nondefensively initiated discussion about this issue, self-direction, initiative, and responsibility often were clarified and the classes moved along smoothly again.

6. SHARING EXPERIENCES AND INSIGHTS, DIFFICULTIES AND ACHIEVEMENTS. Participants did not always achieve their behavior change goals. This often led to fruitful discussions of barriers they encountered in attempting change. It also helped to create a pool of useful suggestions to overcome barriers such as setting goals too high, using unworkable strategies, or having class activities that were not relevant to the participants' lives. Reportback periods on these barriers were valuable in sparking discussion and promoting new insights.

STRENGTHENING THE TRANSFER OF NEW BEHAVIORS

After a few weeks of class, feedback from the facilitators and other class members provided a supportive and reinforcing function for most participants as they learned new behaviors. As people began to experience themselves differently in the classes, some attributed their change to the class rather than to their own actions, and discounted their ability to change in their "outside" lives. This indicated we had not helped participants to see how they were able to willfully transfer behaviors to the rest of their lives.

To facilitate the transfer of new behaviors, the staff assisted participants to become more aware of the internal rewards of healthy behaviors (i.e., noticing how relaxed they felt after doing stretching exercises), and also helped participants identify rewards from their daily lives and relate these rewards to the healthy behaviors. Staff encouraged the participants to see the classes as "real life" and to recognize that their behavior in class could be duplicated outside class.

Staff emphasized how the content areas were interrelated to strengthen broadbased behavior change. For example, when a person begins to exercise regularly, she/he often feels more relaxed and desires healthier foods. The effect of these behaviors combine to multiply the positive benefits. The environmental assertiveness section used a "Making and Maintaining Change" form (Figure 2) to coordinate change in the four content areas.

ENVIRONMENTAL ASSERTIVENESS (EA)

The EA section was the most controversial and probably most unique component of the program. Originally named "Environmental Awareness," staff changed the title to reflect its emphasis on both communication skills and the utilization of those skills to promote a healthier community environment. While stress management, exercise, and nutrition are considered central to any health promotion effort, environmental issues and communication skills are less frequently included. Yet the vast majority of people cannot achieve or maintain optimum health in an unhealthy physical or social environment. Jogging or walking outdoors becomes a hazard on pollution-alert days. The Love Canal incident, the Three-Mile Island nuclear incident, U.S. and Canadian lakes poisoned by acid rain, and the use of toxic materials for home insulation illustrate the importance of concerned individual and community action to restore, maintain and improve the quality of the environment to ensure even the possibility of excellent health. Social policies which reduce benefits to low-income elderly force elders to choose between fuel or food. The arena in which to address these issues effectively is a political one; among the critical skills needed are assertiveness, advocacy, and community organizing.

FIGURE 2

NAME _____

DATE _____

MAKING AND MAINTAINING CHANGE

Current Healthy Activities	Future Goals	Negative Thoughts	Positive Thoughts
Stress Management:			
Exercise:			
Nutrition:			
Environment:			
Assertiveness:			

HELPFUL HINTS

* It's most effective to do something in each of the above areas.
* Set realistic goals.
* Don't try for too much too soon.
* Better to succeed at small goals than to fail at large ones.
* Go at your own pace.
* Get the support from others that you need.
* One week, one day at a time.
* Repeat your positive thoughts regularly, over and over, during the week.
* Congratulate yourself.
* Have fun! If it's not fun, better left undone.

The EA component began with an overview of environmental issues affecting people's health, followed by six to eight weeks of assertiveness skills, with the remaining weeks used to explore issues of interest identified by each group of participants. Often the discussion of environmental health related issues were of immediate relevance to participants--i.e., home safety, crime prevention, senior food cooperatives. Health promotion was approached as a community responsibility in which the social and physical factors affecting health were identified and addressed collectively. Continual emphasis was made to integrate the health promoting behaviors from all the content areas into daily living (see Figure 2).

The group process as developed in the EA sections provided a training ground for participants to clarify their values, refine their communication skills, and develop strategies for action to effect social and environmental changes influencing the health of the community. Skills were taught in a slow progression as participants' confidence and competence grew. A participant's first success with assertiveness behavior might be in class where individual requests are seriously considered. Assertive actions in personal situations might follow. Buoyed by success, particiants were more likely to believe they could address larger issues requiring more complex skills. Through this progression some participants who began the project with no greater hope than to learn about wellness ended up organizing and staffing wellness classes at other senior centers, and others who had never presented to groups became vocal advocates of wellness through the Wellness Speaker's Bureau. Actions other participants took included helping plan a neighborhood food cooperative, initiating a neighborhood exercise class, organizing a crime prevention "block watch," and writing legislators regarding pending bills.

In EA, classes chose to survey a number of environmental issues but usually left specific actions for follow through up to individuals. Some participants have advocated a class organization wherein the group would explore one issue, e.g., nuclear weaponry and war, in depth with the goal of becoming a significant action group related to the issue. The broad overview approach was utilized because (1) a majority of participants expressed a desire for information on a variety of topics, and (2) political beliefs of participants varied widely. To encourage unbiased consideration of each issue we involved, whenever possible, speakers representing different points of view.

ROLE OF THE FACILITATOR

It is the facilitator's understanding and application of health promotion philosophy, knowledge, and group leadership skills that enable the model to work effectively. Participants join the project with the understanding that staff and participants will work together to improve their health using a classroom group model. In the classes the facilitator's primary function is to strengthen participants ability to help each other improve their health. The facilitator provides information and monitors the class interaction with this function in mind. If the class is not proceeding towards its goals, the facilitator acts to bring the class back to focus.

The facilitator mediates between each participant and the group, by helping the group hear the individual and the individual hear the group (Schulman, 1979). For example, when one woman spoke of being robbed and described the debilitating repercussions, other participants appeared agitated and uncomfortable. The facilitator said "Sara is having some painful feelings. Some of you look uncomfortable, I'm wondering if what she is saying touches you, too?" By attending to the individual and the group at the same time, the facilitator opened an emotional and productive discussion of personal experiences on being victimized, and steps participants can take to recover from residual effects and reduce the likelihood of future incidents, both individually and collectively.

The facilitator must be able to assess each person's capacity to assume leadership within the group in order to continually provide appropriate leadership opportunities for each participant. For example, one participant might bring an article and briefly share its contents with the group, while another participant might lead a 15-minute exercise. This learning process was significant in our later efforts to transfer the leadership from professional to volunteer facilitators.

Facilitators need to be committed to promoting health in their own lives if they are to effectively share successes, setbacks, and struggles with the participants, and thus provide a model with whom the participants can identify. The facilitator helps participants link health education information and principles to everyday life. This requires insight and sensitivity to individual lifestyles and the ability to elicit from participants the types of health promoting activities that may be appropriate and feasible in their particular situation (FallCreek and Hooyman, 1981). While the participant may

thrive on ballroom dancing, another may prefer solitary walks as a means to fitness. Income, mobility, sociability, interests, and health status are only a few factors to be considered in applying information to everyday life.

Facilitators can also motivate participants to develop support networks to enhance and maintain behavior change. A facilitator may encourage participants with similar interests to meet outside of class, or enable relatively isolated participants to reach out to neighbors with whom a mutual aid relationship can be developed.

Most of the wellness classes were taught by teams with two or three facilitators sharing the tasks necessary to conduct a group. Mavrolas and Crowfoot (1977) summarize reasons for team facilitation.

1. More information and ideas are available during the planning.
2. More energy (physical and emotional) is available to the group, especially during times of conflict or when handling complicated matters.
3. If a facilitator becomes too personally involved in the discussions, it is easy to hand the job over to the co-facilitator for the time being.
4. Co-facilitation is a way for more people to gain experience and become skilled facilitators.
5. It is less exhausting, demanding, and scary.

Also, attention to group task and process functions can be rotated between facilitators, and the co-facilitators can assist each other by giving feedback and support to each other on an ongoing basis. Finally, a co-facilitation model offers participant volunteers an opportunity to increasingly assume leadership roles by gradually taking in more and more responsibility for group facilitation without having to "go it alone." Correspondingly, other participants are used to the model and therefore find the assumption of leadership roles by their peers quite a natural evolution.

EVALUATION

It would be misleading to speak of evaluation as a separate component of the PLM. Ongoing evaluation was an integral part of both the staff and the class process. Without consistently responding to participant feedback, the model

would not be participatory. Teaching techniques and approaches, from the introductory talks during recruitment through the final graduation ceremony, were all subject to revision based on participant and staff feedback.

The stated purposes of evaluation were to provide feedback to help the facilitators teach more effectively, and to make the class more responsive to the needs of the participants. The participants were asked to (1) teach us how to teach them better, and (2) be assertive in asking for what they wanted. When the structure and process of the classes were evolving, staff solicited feedback weekly and modified the classes considerably. These weekly evaluations used a simple approach. On newsprint the facilitator wrote "what I liked" and "changes I would make" and solicitated response from the class. When general comments were made, staff requested more specific feedback. The interpersonal nature of this evaluation (i.e., the facilitator seeking clarification, paraphrasing) served as a model of good interpersonal communication, and thus was itself an aid in the learning process (Feverstein, 1978). Because staff often made changes in class based on the previous week's feedback, participants experienced immediate success with their assertiveness.

The first participants were the "pioneers" of the project whose input substantially shaped the program for subsequent groups. With subsequent groups, staff solicited structured feedback at the mid and end points of each content area, though we welcomed feedback at any point. For all classes a written evaluation form after each content area solicited information on class materials, ways of improving the class and the facilitator's approach and the accomplishment of individual lifestyle changes.

SUGGESTIONS FOR CHANGE

All of the staff were under the age of 40 at the beginning of the project. The project would have benefitted from the ongoing participation of older team members, instead of the occasional input we solicited from participants. However, in the third year the staff was enriched by the involvement of older facilitators and volunteers who provided an important perspective and balance.

Classes only touched upon sexuality as a topic. Dealing more extensively with this subject would have been appropriate as an aspect of everyday life health behavior and could have led to a deepening of connections between participants. Spiritual aspects of health, though usually addressed, could have been a more central focus by emphasizing the interrelationships of mind, body and spirit. Ageism, sexism and racism could have been explored more fully as EA topics.

There could have been greater development of peer support, providing participants with more individual attention from each other. Due to the broad range of experience, knowledge and learning rates within the classes, not all individuals received the attention and information most appropriate to them. This could be improved by structuring in more assessment activities, working more in smaller groups or pairs, and teaching a basic peer counseling format, perhaps tied to the assertiveness training and communication skills section.

The knowledge and practice base of the staff could have been broadened and enriched with more input from health educators, nurses, nutritionists, or allied professionals who shared our teaching philosophy.

Occasionally, staff would identify participants' needs which could be best met by other agencies. The success of our referral efforts depended upon the knowledge of individual staff about community resources and their skill in referring and following through. Activities to strengthen the referral process could have included inservice training on available community resources and presentations by other senior center personnel.

In future programs, more attention should be given to the continuity of services through carefully planned individualized referrals to existing community health promotion programs. This could involve spending time toward the end of the program with each participant designing their ongoing plans for wellness, with staff consulting and providing resource information.

While teaching sequentially, staff discovered a useful order of content areas was exercise first, stress management second, and nutrition last. Exercising together first loosened up, relaxed, and engaged the participants in the classes. Since issues in the nutrition section consistently generated the most controversy and emotionally charged discussion, staff found these discussions easier to facilitate after the

groups were well acquainted and communication skills had been enhanced.

A change suggested by some participants would be a greater integration of the four content areas within the classes. As taught, the participants studied nutrition, stress management, and exercise sequentially. Some participants reported they would have preferred to weave these components together throughout the program.

CONCLUSION

There is ideally no end point with the participatory learning model. Though the classes end, the participants are left with skills that can be applied to other aspects of their lives. Throughout the classes, the participants and staff have been using their knowledge and skills in their daily lives, and have shared aspects of their lives in the classes for clarification, analysis and evaluation. From the outset, participants were encouraged to invest themselves in the classes, to take risks, to ask for and expect support for articulating and taking action toward their goals. We hope that the rewards of this proactive approach to life will lead all of us to continue actively participating and learning throughout our lives.

REFERENCES

FallCreek, S., & Hooyman, N. Roles for social workers in health promotion programs. Unpublished paper, School of Social Work, University of Washington, 1981.

Feverstein, M.T. The education approach to evaluation: An appropriate technology for a rural health program. International Journal of Health Education, 21(1): 56-64, 1978, p. 58.

Freire, P. Education for critical consciousness. New York, NY: The Seaburg Press, 1973.

Harris, L. & Associates, Inc. Health maintenance. Commissioned by Pacific Mutual Life Insurance, Co. November, 1978.

Maier, H. Human functioning as an interpersonal whole: The dimensions of affect, behavior and cognition. In CSWE's Teaching for competence in the delivery of direct services. New York, NY: Council on Social Work Education, 1976.

Mavrolas, P., & Crowfoot, J. Group process. Environmental Advocacy Program, School of Natural Resources, University of Michigan, December, 1977.

Oberman, E. Educational model in behavioral training. Social Work, 23(2), p. 123, 1978.

Schwartz, W. From the foreword to L. Shulman's The skills of helping individuals and groups. Itasca, IL: F.E. Peacock Publishers, Inc., 1979.

Shulman, L. The skills of helping individuals and groups. Itasca, IL: F.E. Peacock Publishers, Inc., 1979, p. 118-119.

Wallingford Wellness Project staff. Health promotion educational materials. Seattle, WA: Center for Social Welfare Research, School of Social Work, University of Washington, January, 1982.

Participant Recruitment
or
What if we gave a party and nobody came?

Lisa Christopherson
James Barrett-DeLong
Sue Bailey Stam

Recruitment of viable participant groups is sometimes the downfall of otherwise well planned and potentially valuable social programs for older adults. Staff and a few community people, in the initial creative flush of program development, may be convinced that the benefits of a new program or service will be boundless. Potential participants, may be skeptical and perhaps even wary of what they perceive as a "here today, gone tomorrow" or "we've got all the answers" program. This is even more likely when the program in question is particularly innovative or radically different from any previously experienced.

Conscious of these potential pitfalls, the Wallingford Wellness Project (WWP) staff approached each recruitment effort deliberately and somewhat cautiously. With each effort, our staff learned more about effective and appropriate recruitment tactics, and we reinforced the principle that each recruitment effort should be planned as carefully as the first so that the plan is appropriate to everchanging dynamics of the potential participants, the resources (people and funds) available, and the long and short-term program goals.

The key elements of each recruitment effort are presented here as a means for further evaluating effectiveness, the appropriateness of tactics and their effect on participation including expectations, commitment and dropouts. We also hope that both the process descriptions and the analyses will be useful for others in recruitment efforts for their own established or new programs.

GETTING STARTED. . .THE FIRST PARTICIPANT GROUP

In the fall of 1979, the WWP staff began planning the recruitment of Project participants. To obtain the total desired number of participants during the course of the Project, staff structured the program with three cohort

groups. Therefore, recruitment was correspondingly designed in three phases.

Basic community organizing principles were followed to enhance Project visibility and acceptance, as well as build a network of community relationships. Contacts were made with community elders and younger community leaders as well as area service providers to gain an understanding of the Wallingford community's history and development, to assess the need for community services for the elderly, and to discuss health promotion programming in general. This assessment identified several needs of older adults: the desire to continue to feel useful; the need for personal care (especially footcare); transportation; education regarding existing resources; home help; social programs; and nutritional information. In addition, service providers noted a need for an accurate identification of service gaps in the North End health-care delivery system. Some of these needs corresponded to those cited in a previous survey of over 100 Wallingford seniors which listed nutritional programs, health care, social activities, transportation, and educational programs as primary services needed.

Staff thus became familiar with overall characteristics of the Wallingford community and, in particular, services for older adults, attitudes of and toward older adults, and their roles in the community and in the newly organized Wallingford Senior Center (WSC). With this historical perspective and initial community relationship building underway, a meeting was scheduled with community leaders to discuss effective recruitment tactics. A one-page handout outlined goals and specific questions to be addressed at the meeting (Figure 1). Recruitment suggestions were solicited and prioritized at that meeting. With that foundation, staff planned strategies and materials for recruitment.

A public relations campaign was designed to increase overall visibility, generate enthusiasm, and invite participation in the Project. A brochure was developed and distributed to service providers, community contacts, and potential participants. Media publicity was obtained including a feature story published in the community newspaper describing the Project's background and inviting people to participate. Posters and flyers were displayed by key local businesses and organizations. In addition, prior to active recruitment, one of the staff members had taught an exercise class for the WSC for three months. This personal interaction with class members provided a unique opportunity for generating interest in the Project and building trust between staff and potential participants.

FIGURE 1

FIRST RECRUITMENT MEETING HANDOUT

The Wallingford Wellness Project, a program of the Wallingford Senior Center, will be developing a number of intergenerational programs dealing with health promotion. These programs will attempt to show how exercising, learning to control stress, and eating healthy foods can improve one's health and prevent illness. We want to involve people in the Wallingford Community to such an extent that they are leading the programs and supporting each other in making these lifestyle changes. This is a 2½-year demonstration and research project in which we will measure changes in health and living habits, and which we hope will be continued by all age groups in the community long after the research is completed.

We are looking for people to participate in the project. We would like to find 25 people over 75, 50 people over 60, and 50 people 60 or younger in the Wallingford community. To find these people we need your help in answering the following questions:

1. What do we do to find out where people are? Who do we talk to? What information do we look for?
2. Who are the service providers in the Wallingford community? Of these service providers, who will support this project?
3. What will people want to know about the project before they will get involved? What can we tell them that will lessen any fears and generate excitement?
4. What kind of communication tools should we develop, i.e., brochures, press releases, television spots, etc.?
5. How should we actually approach people?, i.e., should we go door to door, hold community meetings, telephone, work through existing organizations, etc.?

The WSC helped by lending credibility to the Project and its staff, announcing the recruitment events at Center functions and in the Center newsletter, encouraging word-of-mouth publicity, and offering opportunities for socializing between staff and Center members. Additional interest was generated through visits by the WSC Director and a WWP staff person to local churches.

One of the most important recruitment tools was the personal phone call used to extend invitations to people, remind them about attending public presentations held at the WSC, and share general information about the Project. Names and phone numbers came from the WSC, church visits, service providers, and people who called for information after reading the community paper article.

A goal of the public relations campaign was to persuade people to attend a 90-minute presentation describing the program. These meetings included presentations and sample activities to introduce people to health promotion concepts and involve them in the process of examining their own health-styles. For example, potential participants filled out and discussed a "Simplified Self-Scoring Test of Heart Attack and Stroke Risk" (see Foreword). Seven of these presentations were held at the WSC and two at local churches. Fifty-seven percent of those attending the WSC meetings (a total of 72 people) and sixteen people attending the church meetings filled out screening questionnaires confirming their interest in Project participation. These public meetings were attended by as few as six people and as many as forty-four. A few people signed up for the program after hearing about it in some other way, including one person referred by a service provider.

Sign-up consisted of completing a screening questionnaire. The questionnaire elicited information about physical mobility as well as chronic conditions and use of prescription medications that might affect participation in the Project. These forms were generally reviewed by medical staff (a physician's assistant and a nurse both served on the staff at different times). Some people were specifically requested to secure release of liability forms from their health care providers. Other potential participants had the option of securing a medical release or signing a personal release of liability.

After the initial screening, baseline research data was gathered through personal interviews. Participation in an introductory workshop was scheduled at this time.

During the workshops, which took place a week before the classes began, participants signed up for one of the four available weekly time slots for health promotion classes. These four groups were scheduled to meet for the following twenty-four weeks.

Over a period of ten weeks, sixty people were recruited and interviewed using this process. Fifty-three actually attended class; seven dropped out before classes began for reasons ranging from discomfort with the sensitivity of information requested during the interview process to schedule conflicts. Initially, priority for enrollment was given to Wallingford residents first, then WSC members who were not Wallingford residents, and finally to other Seattle residents. Overall, twenty-eight Wallingford residents (including eight WSC members) and twenty-five nonresidents (including seven WSC members) participated. Seventeen were under 60 years of age, thirty between 60-75 and six over 75. Altogether there were forty-four women and nine men who ventured with us as Project pioneers.

Scheduling was modified according to participant input during the initial classes, and was finally set for a three-hour block of class time (1-1/2 hours each in Environmental Assertiveness and one other subject area) once per week. Generally, older participants preferred daytime classes while workers of all ages required evening sessions. Nine people eventually dropped out for a variety of reasons including illness, job conflict, familiarity with the content, and feeling overwhelmed by questionnaires and paperwork required for program evaluation. Ultimately, forty-four participants graduated from the twenty-four week program in September of 1980. In order to graduate, a participant was required to have attended a minimum of three sessions in each subject area. A festive graduation ceremony was held which included the receipt of certificates as well as recognition from city officials, the Regional Director of the Administration on Aging, staff and participants themselves.

NO LONGER THE GREAT UNKNOWN - THE SECOND PARTICIPANT GROUP

In several ways, recruiting for the second series of classes was easier than the initial effort. The ability to enlist help from the first group of graduates, enthusiastic

media coverage as a result of the program's increasing popularity, and the advantages of hindsight in planning were great benefits.

A timeline was developed by the recruitment coordinator (see Figure 2) which included proven as well as new recruitment ideas. This timeline helped staff members organize tasks and visualize the entire process.

Assistance from graduates, especially members of the Advisory Committee, was a major factor in the success of this effort. They helped recruit participants from other groups to which they belonged, such as the American Association of Retired Persons and Gray Panthers. In a number of instances, they served as liaisons between the staff and these organizations, helped set up presentations, and gave testimonials. They also recommended participation to family and friends and brought potential participants to visit classes and graduation in an "each one recruit one" effort.

Media publicity, well-planned from the beginning of the first recruitment drive, was again instrumental in attracting people to the program. Newspaper, radio and television contacts continued to be responsive to public relations efforts. WWP staff and participants were featured in television news stories and interviews as well as an educational documentary produced by the local public television station. A feature story published in the Outlook, a neighborhood newspaper, in June of 1980 (see Appendix K) and a Seattle Times September 1980 article, emphasizing the personal value of the program, drew over twenty-five inquiries from interested readers and potential participants. Again, presentations were held at a number of sites including church groups, other senior centers, and health centers. The staff and graduates participated in the ENCORE senior information fair, an annual city-sponsored event in Seattle. Five public presentations, similar to those held for the first recruitment effort, were held at the WSC. These were publicized through word-of-mouth, flyers and posters, public service announcements, and other media coverage. Cover letters, a schedule of events, and an information flyer (see Figure 3) were sent to people who had indicated prior interest in the program but had been unable to participate and to drop-outs from the first group. This flyer answered the most commonly asked questions about the Project. Primary Health Care Associates, an area clinic, sent out a note to its older clients encouraging them to attend one of the introductory presentations, and other health care providers referred clients to this wellness program.

FIGURE 2

COHORT II RECRUITMENT TIMELINE

TASKS	JULY 14-17	JULY 21-25	JULY 28-31	AUGUST 4-7	AUGUST 11-14	AUGUST 18-21	AUGUST 25-28	SEPTEMBER 1-5	SEPTEMBER 8-11	SEPTEMBER 15-19
PR										
1. brochure				xxxxx						
2. flyer			xxxxx							
3. poster			xxxxx							
4. press release & psa				xxxxx						
5. feature						xxxxx				
6. interviews					xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx					
7. newsletter article				xxxxx						
8. evaluation										****
Service Providers										
1. list				xxxxx						
2. WWP coordination				xxxxx						
3. material distribution				xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx						
4. contact providers					xxxxxxxxxxxxxxxx					
5. follow-through						xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx				
6. develop workshop			xxxxxxxxxxxxxxxxxx							
7. workshop							xxxxx			
8. evaluation										****
Participant Organizations										
1. list		xxxxxxxxxxxxxxxxxxxxx								
2. WWP coordination			xxxxxxxxxxxxxxxxxx							
3. develop presentation				xxxxx						
4. arrange presentation					xxxxxxxxxxxxx					
5. follow-through							xxxxxxxxxxxxxxxxxx			
6. evaluation										****
Wallingford Sr. Ctr.- Wellness Project										
1. advisory committee & steering committee	xxxxx									
2. cohort I dropouts					xxxxxxxxxxxxxx					
3. indicated interest					xxxxxxxxxxxxxx					
4. cohort I party									xxxxx	
5. evaluation										****
Large Grp. Presentations							8/27	9/4,5	9/9	9/30, 10/1

FIGURE 3

WALLINGFORD WELLNESS PROJECT
4649 Sunnyside, North
Seattle, WA 98103
(206) 447-7821 or -7825, M - Th

OFTEN ASKED QUESTIONS ABOUT THE WALLINGFORD WELLNESS PROJECT

WHO IS ELIGIBLE?

The Project is for all people at all ages. Older adults and family groups are especially encouraged to participate. A simple screening questionnaire is used to determine overall health status.

HOW ARE THE CLASSES STRUCTURED?

Four classes are offered: nutrition, stress management, physical fitness and environmental awareness/assertiveness. The classes last 21 weeks altogether. Participants attend two classes a week. Both classes are scheduled during a three hour block of time, one day a week. Evening classes will be offered.

ATTENDANCE?

We encourage attendance as regularly as possible since full participation is important to making healthy changes. We recognize that people occasionally have vacations or other commitments and will sometimes miss class.

RESEARCH?

Project participants are asked to take part in the research component of the Project. A staff member will arrange a 1-2 hour interview with each participant before and after the actual program.

Participants of all ages contribute to the research effort by periodically evaluating the classes and by developing their own personal contracts for healthy living.

COST?

All Wallingford Wellness Project classes and materials are free to participants.

The first public meeting on August 27th, 1980, was designed for service providers from local agencies. Over 100 letters of invitation were sent out, and forty-five people attended. This presentation included a more extensive treatment of the various content areas in the form of a "sampling" of program activities. An information exchange table was made available where people attending could share materials about their own programs. They were also encouraged to take brochures, posters, and their enthusiasm about the program back to their staff and clients.

The general format for all the public presentations included the risk factor analysis, a discussion of how changes in health practices can lessen the probability of chronic illnesses, and a brief description and experience of the program content areas. A locally produced television videotape helped provide an insight into Project involvement. A "healthy snack" break offered an opportunity for people to ask questions, review Project materials, and complete the screening questionnaire. People were encouraged to sign up even if they were not yet fully committed to participating.

Again, baseline interviews were scheduled and held. Participants were asked to bring the final two parts of the questionnaire and a one-day diet survey to the introductory workshop offered before the classes began. The purposes of the workshops were, as before, to enable participants to gain a deeper understanding of the program goals and the methods used to achieve those goals; to enable them to begin developing comfortable and supportive relationships with other participants and the staff; and to allow people to sign up for one of the six class sections. A brief description of the workshop follows to illustrate how these objectives were met. Detailed workshop materials are included in the Health Promotion Educational Materials (1982) and Participant Recruitment II/Introductory Workshop (1981) packets.

Volunteers from the first group greeted new participants and helped them through the registration procedure at the introductory workshop. Project materials, including a nutritionally-oriented guessing game, were set out in the lobby to encourage mingling and to spark curiosity. The workshop itself began with an exercise to help everyone, including the staff, relax and feel a sense of camaraderie. The workshops recapped the value of changing health behaviors, provided an overview of the philosophy and goals of the Project, and engaged the participants in experiential activities.

People participated in a relaxing neck and shoulder massage, nonstrenuous stretching and limbering exercises, a nutrition game, and an imaginary journey to a healthy place followed by a discussion of societal and personal health. Participants then signed up for class sections. Staff assessed transportation needs and coordinated carpooling arrangements.

This recruitment drive was very successful. Approximately 170 people indicated they wanted to participate and 139 began classes. (A waiting list was kept for those who could not be accomodated due to limited space. Additions to this list were made throughout the program.) Fifty-eight of these people were under the age of 60, sixty-two were between 60 and 75, and nineteen were over 75. Seventy-seven women and twenty-five men comprised this second cohort. We had hoped to reach isolated elders, disabled persons, minorities, Wallingford residents, and to secure participation of two or more family members together. These goals were met to varying degrees.

The outreach effort was successful in recruiting sixteen disabled participants including people using canes, walkers and one woman in a wheelchair who attended with her two sisters. People with physical disabilities or limitations, including dysphasia, hearing loss, severe arthritis, and the limiting affects of stroke took part in the program at their own level of activity. The outreach effort to minorities could have been more vigorous; as a result only three minority women participated. Almost one-third of the graduates participated with a relative (twenty-six people from twelve family groups), and many more participated with close friends.

Unlike the first series, a majority of participants came from the larger metropolitan Seattle area outside of Wallingford. To our pleasant surprise, a number of service providers enrolled who worked in other senior centers, senior nutrition sites, housing projects, educational and recreational programs, nursing, and social work. They participated to learn about health promotion specifically with an older population, as well as to enhance their own healthstyles. Project classes provided information and skills which they could modify to their particular clientele and setting. Participating along with other people who were comparable in many ways to their clients offered first-hand experience to the stumbling blocks and successes inherent in behavioral and lifestyle change of older adults.

THE THIRD TIME AROUND

Recruitment of the third group of participants was substantially different from previous efforts. Staff had a long waiting list that had been generated throughout the second series of classes. The list included the people who were unable to get into the second program due to space limitations. Further, it included people who had called in response to ongoing publicity or at the suggestion of their friends, people who attended Seattle's City Fair and viewed the Wellness Project display, and people who called at the recommendation of service providers. Therefore, this recruitment effort differed from previous efforts because public presentations and a publicity campaign were not involved. Though considerable staff time was saved, there were some repercussions from these changes which are discussed later.

Staff contacted, by phone, everyone on the list of over 150 people. Eighty people who indicated a definite desire to participate were invited to a welcoming picnic held in August of 1981. Volunteer advocates played a major role in the coordination of this picnic. Screening questionnaires, liability release forms, and class scheduling information were mailed to potential participants. Sixty-five people initially registered for classes. Registration by mail was also an option.

Another major difference was that this third cohort did not participate in the research process and, therefore, did not have to complete the four-part interview/questionnaire.

Finally, the third group was offered a 14-week series of classes instead of the 24- or 21-week format. The reasons for this included manageability for newly trained volunteer teachers, funding constraints, and limitations of the Fall schedule. The effects of classes having been taught by trained volunteers is discussed in the Transfer of Leadership chapter. This unpaid staff consisted of graduate students, program graduates, and other health professionals who participated in a WWP skill development workshop during the summer of 1981.

Fifty-eight people began classes: twenty-six under age 60, twenty-six between 60 and 75, and six over 75 years of age. Forty-five were women and thirteen were men. A total of twenty-one people dropped from the program for reasons including transportation problems, moving, schedule conflicts, and feeling uncomfortable in the classes. In all, thirty-seven people graduated from this participant group. Another

festive graduation celebration was held that included relatives and friends, former graduates, the volunteer teachers (Wellness Advocates), and WSC and WWP staff. All joined together to recognize the achievements of this third group of wellness participants.

THE FOURTH PARTICIPANT GROUP - A NEW STYLE

As the Project ends, the fourth participant group is involved in Environmental Assertiveness and Nutrition classes. These classes are being sponsored by the WSC and taught by Wellness Advocates. Recruitment for this group came primarily from yet another "waiting list" which had been compiled from interested callers and people who had not been able to participate in the third series of classes.

Advocates called the people on this list, explained the new class format to them and arranged for them to attend an introductory session similar to those held for the other three groups. This fourth training program differs from previous classes in several ways. The classes are separated by a lunch break during which social interaction between the participants and people involved in other WSC activities is encouraged. Participants are being encouraged to help determine the direction of the WSC wellness classes. Many of the people who attended the introductory sessions subsequently brought friends along to participate in this modified program. So far, thirty people have attended at least one class, and enthusiasm remains high.

EVALUATION - THE ADVANTAGES OF HINDSIGHT

Reviewing and evaluating the various recruitment tactics used and results achieved was helpful for WWP staff and hopefully can be useful for future planning. An overview of the key components of the overall recruitment process as identified by staff and participant evaluations is detailed below.

PLANNING was critical to each recruitment effort. A well-planned, or poorly planned, recruitment campaign sets the tone for the ensuing program. Potential participants may assume that a well-planned recruitment campaign is likely to be followed by a well-planned program.

In retrospect, it would have been useful to have had at least six months planning time before recruitment of the first group. It is crucial to allow enough time for careful planning with maximum constructive input from a variety of sources. Ample lead time also enables community relationships to be built more carefully. Specifically, for the WWP, it may have been worthwhile for a promotional piece to have been placed in a local paper when the decision to place the Project in the Wallingford neighborhood was made. An ongoing liaison person available to the Wallingford Senior Center and community would have been valuable as well.

The recruitment timeline developed for the recruitment of the second group served to involve the total staff and to pinpoint effective strategies. Planning tools such as this proved to be helpful to the staff.

THE PERSONAL PHONE CALL was one of the most important recruitment methods. Though time consuming, it established a personal connection between Project staff and potential participants. Personal contact with a staff person was cited as a significant factor in people's decisions to participate. For the fourth group of participants, a telephone call from a Wellness Advocate or staff person was the primary recruitment method.

ENTHUSIASTIC PARTICIPANTS were equally important. Beginning with the second group recruitment, participants were very involved in sharing their enthusiasm either informally with friends and neighbors, or formally by arranging presentations with other organizations with whom they were involved. Some graduates contributed to media efforts by agreeing to be interviewed or filmed and participated in public presentations given at events such as ENCORE and City Fair. Satisfied participants are probably the primary recruitment aid.

MEDIA COVERAGE was another factor cited by a significant percentage of people as having positively influenced them to participate. Many people originally heard about the Project through the media especially prior to and during the second and third recruitment efforts. Staff initially pursued media coverage and planned an ongoing public relations campaign. As the WWP became more visible and popular, the media sought out the Project for special interest features. An unusual amount of publicity was generated during the life of the Project.

Staff did not actively pursue minority group or disabled participants. Press releases were sent to media serving minority groups, and service providers serving the disabled were contacted. However, followup was not as vigorous as it might have been. Staff agreed that the program content and format was designed primarily for a white working class participant group and that, to be useful with other groups, modifications would be necessary.

About 6,000 copies of the Project brochure were disseminated over a 2½-year period. The brochure was cited by participants as influencing their decision to participate, and in addition, served to enhance Project visibility nationwide.

Posters and articles placed in newsletters, other than the WSC newsletter, were not particularly useful in establishing initial contact or encouraging participation according to participant feedback. However, newspaper articles and word-of-mouth were extremely useful.

REPEATEDLY INVOLVING THE LOCAL COMMUNITY through publicity, contacts, and cultivating support was valuable and could have been developed further. The exercise class taught by a staff member prior to the first recruitment effort was an excellent pre-recruitment strategy to establish credibility and support. This personal interaction with potential class members provided a unique opportunity to generate interest in the Project and build trust. Also, in the first group, a large percentage of the participants found out about the program through their local churches.

Additional low-key outreach to the community, such as participation in community council meetings or other community events prior to actual recruitment would have helped to dispel community skepticism. Such outreach might have increased the level of participation on the part of Wallingford residents and particularly WSC members who, in many cases, were uncomfortable with some aspects of this innovative program as well as with university-related research-oriented endeavors.

THE PUBLIC PRESENTATIONS were identified by a majority of participants in the first two groups as significantly influencing their decisions to participate. The risk factor analysis was an influential tool. This "Simplified Self-Scoring Test of Heart Attack and Stroke Risk" enabled people to measure their lifestyle habits in six areas. It was a first step for many people in identifying specific areas for

improving their own healthstyles and, therefore, acted as a motivation for participating in the program.

The most common reasons cited by a sample of the first group of participants for participating in a wellness program included a desire to improve health generally, to engage in physical activities, to gain nutritional information, and to increase social contacts. The presentations helped people determine whether or not this program was likely to meet their desires. For the third group, the presentations were replaced with an informal introductory picnic coordinated by the staff but primarily conducted by program graduates. Some staff members believe that, while the polished presentations and the risk factor analysis inspired involvement, they also led participants to view the Project staff initially as "experts" which hindered progress in implementing the participatory learning model. On the other hand, lack of presentations of this type, as in the third group, led to ambiguity regarding program content, format, and attendance expectations.

It is evident that the style and content of public presentations influence expectations regarding program content and format. Therefore, wellness program planners would benefit by developing presentations that set the tone for the classes that follow.

INTRODUCTORY WORKSHOPS were very useful to secure commitment to participate. They helped to dispel apprehensions or misunderstandings about the program and further enhanced commitment to the social structure of the group. The staff ultimately reasoned that the order in which the "samples" for each subject area were introduced was of some significance in creating comfort and that exercise, as the most familiar, should precede stress management and be followed by nutrition and environmental assertiveness, which are more controversial.

ONE-TO-ONE PRE-PROGRAM INTERVIEWS, required of the first and second groups to meet the research requirements of the Project, influenced attrition prior to the beginning of classes and during classes. A number of people who dropped out of the Project before and during classes indicated that the amount of paperwork and/or the personal nature of the information requested on the research questionnaires affected their decisions. On the other hand, relationships, begun during the baseline interviews, often endured and may well have increased some participants' commitment to the program. Many people who dropped out of

the third group stated they did so because of life situation problems. Perhaps greater personal involvement with other group members and staff may have encouraged them to continue to use the wellness group as a resource. Staff members who worked with the third group believe that an initial personal interview with participants is valuable to help people understand staff expectations and to become invested in the program.

FLEXIBLE SCHEDULING of presentations, introductory workshops and classes to meet participant needs and limitations was an important factor in maintaining participation. Most people preferred daytime over evening meetings. Fear of crime and failing vision discourage older people from going out at night, especially those depending on public transportation. The best attended initial recruitment presentations followed the noon meal at WSC. Participants in the first group asked to have classes combined into a one-time-per-week, three-hour block. Transportation problems and cost reinforce a combined schedule.

CONCLUSIONS

Judging from this experience and evaluation, the most essential recruitment tools are the "Five Ps": planning, personal contact, phone calls, publicity (media), and presentations. Each of these is important in building credibility, relationships, interest, and, finally, personal investment on the part of new participants.

Unfortunately, this is not a formula for recruitment that will work equally well for every program. Each program is different with unique resources and needs, just as the Wallingford Wellness Project differed from one recruitment to the next. Wellness, as it continues in the Wallingford Senior Center, has resources and limitations that differ from those available during the demonstration period. For example, a Speaker's Bureau is now available to publicize the classes at other sites, and wellness is no longer a "strange notion" to Wallingford citizens. There will be less paid staff time to devote to recruitment. However, an eager group of graduates and volunteer advocates continue to encourage people they meet to get involved in health promotion classes.

Participants' experiences during recruitment decidely affect their expectations, level of participation, and commitment, including the likelihood of their completing the program. The tactics and strategies implied by the "Five Ps"

are important, and so is a sixth "P"--personal commitment. Commitment suggests that the staff be flexible, responsive and patient when, for instance, a recruitment plan doesn't proceed in the linear fashion originally envisioned. This crucial element cannot be planned or strategized in the same way as the others, but it can be cultivated and maintained through a participatory process. Personal commitment is perhaps the most important resource available to the Wallingford Senior Center and other sites in recruiting for future health promotion classes. As participants invest themselves in the pursuit of wellness, they become recruiters and resources. While staff agree that ongoing programming needs at least one paid staff person to coordinate, the commitment of people whose lives have been enriched by wellness, combined with the "Five Ps," can go a long way towards ensuring ongoing groups of enthusiastic participants.

REFERENCES

Wallingford Wellness Project Staff. Health promotion educational materials. Seattle, WA: Center for Social Welfare Research, School of Social Work, University of Washington, January, 1982.

Wallingford Wellness Project Staff. Participant recruitment process II/Introductory workshops. Seattle, WA: Center for Social Welfare Research, School of Social Work, University of Washington, June, 1981.

The Wellness Support Group
A Model for Participant Directed Programs

Kari Knutson
Sue Bailey Stam

> "I remember the old homestead where I grew up. Every person in the community was definitely working together. They were your friends. Their problems were your problems and yours were theirs. Let's not lose that. Cities have very few communities. Let's bring ourselves together with that old pioneer spirit!"
>
> Della Patch
> WWP Graduate

Life on Della's homestead stands in sharp contrast to life for most people in present day America. The fabric of social relationships has changed, and we no longer depend on and support each other in the same way that existed on the homestead. These changes have affected everyone in society, including older people.

For many, old age in America is characterized by the loss of friends and relatives, a central family role, and former group associations. These connections between the individual and the social environment form support networks through which a person can maintain her/his identity and receive physical, emotional, and social support. The absence and/or diminishing of support networks contributes to feelings of loneliness and depression which can have a significant negative impact on mental and physical health (Lowenthal, 1968).

To enhance the health of individuals and the society, how can we marshall Della's pioneer spirit in the 1980s? One response is the self-help support group, defined as a small group of people who come together voluntarily for mutual aid and the accomplishment of specific purposes through face to face social interactions in which there is personal responsibility for action (Katz and Bender, 1976). Through support groups older adults can receive personal support as well as

develop a collective response to a fragmented society which refuses to recognize and value their rich and diverse potential.

This spirit helped originate and sustain the Wallingford Wellness Project's (WWP) support group. It developed at the end of the basic health promotion training program held at the Wallingford Senior Center when several of the 44 graduates of the first group, including Della Patch, expressed a desire to continue meeting together. And they did! The Wellness Support Group was off and running.

GOALS

The purpose of this ongoing support group was initially seen as supporting one another in maintaining the positive lifestyle changes made during the 24 week health promotion program by providing an opportunity to get together, share ideas and concerns, and continue involvement in wellness activities. It also provided a foundation for developing friendships and support systems into a social network built on common interests and activities, shared and valued goals, and the enhancement of morale and the quality of life. After meeting for six months, the support group explicitly defined its goals as:

1. To create a group of people who provide support to each other.
2. To help maintain and develop positive health behaviors.
3. To enable members to be in control of their lives and actions.
4. To establish a group of people who have the skills and enthusiasm to help conduct an ongoing wellness program.

WELLNESS SUPPORT GROUP MODEL AND PROCESS

From the very first planning meeting it was the intention of the WWP staff that the Wellness Support Group members reinforce and/or develop the skills, knowledge and confidence needed to eventually plan and run the group themselves. Members had just completed the health promotion training program designed from a groupwork, highly participatory educational perspective. Therefore, people had already developed varying degrees of trust and confidence in being partners

with the staff in the planning and learning process. As Silverman (1980) suggests, the primary goal of the professional in setting up a support group is to maximize the capabilities of the members to the point that they take charge of the organization. However, acceptance of leadership roles by group members was hesitant at first, seemingly based on a lifelong strongly reinforced tendency to rely on the "experts" as well as a tendency to discount one's own vast reservoir of experiences and skills. This has changed over time as those involved have continued to gain confidence in themselves and each other as planners and facilitators and as they have learned to share group tasks.

Staff worked as partners with the support group members to model and enhance their group process skills, to share knowledge of project and community resources, and to facilitate ongoing skill development. In the beginning stages of the group's existence the staff played a more active role in facilitating the meetings. Gradually the participants took on increased responsibility for group planning and leadership with staff limiting their roles to those of resource persons and consultants. This transition evolved over eight months after the first group of graduates completed the program and only three months for the second group of graduates. The following format was developed by the group for their weekly two hour meeting: gathering, exercise, catchup, brags, announcements, planning, break, and speakers.

GATHERING

Before the group begins, the participants usually engage in informal socializing. For some this is a special time when they are able to talk with friends, though others in the group meet or talk many times during the week.

EXERCISES

During the first 15-20 minutes, each of the participants leads the group in a few minutes of a favorite exercise or two. These exercises are fun, easy movements and stretches and help to focus the group. They provide an opportunity for ongoing skill development in that each person assumes a leadership role in sharing an exercise and leading the group.

CATCHUP

After the exercises the group gathers at a table and someone recounts what the group did the previous week. This activity refreshes memories and provides an update for those people who were not at the last meeting. The group keeps an ongoing journal documenting what happens at each meeting and who attends.

HEALTHSTYLE BRAGS

Different group members relate what they have done during the past week in their pursuit of good health. These brags can range from dealing with a stressful confrontation with a neighbor or participating in an aerobic dance class, to demonstrating for keeping the public health hospital open. "Healthstyle brags" provide an opportunity to share accomplishments, cite problems, and receive group support and feedback. This sharing, led by a group member, also provides an opportunity for practicing group facilitation.

ANNOUNCEMENTS

Group members share information on project and center-related activities as well as community activities and concerns. Books, newspaper articles, television programs, and other health related information are also shared.

PLANNING

Once a month the group plans its agenda for the coming month. This involves reviewing the activities and speakers from the previous months which are divided into the following categories: stress management, exercise, environmental assertiveness, nutrition and skill development. Group members suggest topics and activities, and the group decides on a schedule for the coming month. One or more participants assume responsibility for contacting speakers, writing an article describing the upcoming agenda for the senior center newsletter, and writing thank you letters to the people who come to speak.

BREAK

After the first hour, the group takes a break for refreshments and socializing. People often bring nutritious snacks for others to taste (often followed by requests for recipes).

SPEAKERS AND OPEN FORUM

The second hour's activities usually involve information sharing in one of the five content areas mentioned. The group invites speakers from the community as well as listening to presentations by group participants. With controversial topics, the group attempts to have all perspectives presented. For example, after a Greenpeace representative gave a presentation against allowing supertankers into Puget Sound, a speaker from Clean Sound Coop was invited to speak from a pro-supertanker point of view. Explaining both sides of an issue helps group members determine their own positions and often leads to much more in-depth discussion.

The group decided to have "open forum" once a month to share special events, concerns, or problems of those present. Difficulties such as intra-group communication problems and daycare arrangements for an ill spouse and joys such as vacation plans and visiting grandchildren have been discussed. One session that involved resolving conflicts between group members ended appropriately with a group hug, a "wellness hug" of course!

SKILL DEVELOPMENT

Skill development was intentionally woven into various components of the weekly meetings. This type of training involved practicing group facilitation and planning skills in the safe and supportive environment of the group. Some of the ongoing skill development training included: leading exercises, facilitating part of the meeting, helping plan an exercise class for the Senior Center (now taught by a support group participant), and planning and organizing the group's own monthly program.

The process of this training involved asking participants if someone would like to assume a role such as leading exercises. In the case of facilitation, if desired, the participant was given feedback by the group. When a person

took responsibility for writing an article or contacting speakers, they were recognized and appreciated for their work. The staff modelled behaviors and provided tools to enhance this process for participants. Several group members participated in assisting with other aspects of the project such as participation on the Advisory Committee. This also enhanced skill development.

In addition, a series of workshops was held to enhance skill and leadership development for support group members and other people interested in teaching wellness as volunteer Wellness Advocates. The focus of the first series was on individual and group skills. The second workshop series was designed to enhance facilitation and teaching skills. Skill training in the workshops and as an ongoing part of support group activities complemented each other. Group members took the opportunity during meetings to experiment with and get feedback on skills learned in the workshop setting.

EVALUATION AND EFFECTIVENESS

Support groups offer peer support and reinforcement which is crucial in maintaining behavioral changes. Health education goes only so far in presenting information and encouraging the adoption of healthy behaviors. Changing health behaviors requires experimenting with new behaviors and skills, ongoing practice and reinforcement for this practice. Research has indicated that changing lifestyle habits requires a minimum of six months of practice for the new behavior to become internalized. Therefore, the ongoing support and reinforcement of a peer group can play an essential role in this process. Support groups offer a useful vehicle to gain commitment to lifestyle changes and to maintaining healthy improvements.

Support groups also offer the opportunity for a person to be one of a community connected by common goals. As isolation and loss of group contacts can become problems in times of transition as we age, the group also provides a place to make new associations.

Finally, support groups provide an excellent opportunity to assist older adults in acquiring participatory skills and learning new roles. Tapping into the rich and diverse skills of these wonderful participants can provide communities with valuable resources as participants apply their own talents, as well as knowledge and energy gained from the group, to encourage their family, friends and fellow citizens toward healthier personal and community lives.

After seven months, an evaluation of the support group program was conducted to assess how effective the group's activities had been in meeting the goals of support, maintenance of change, empowerment, and skill development. The evaluation showed that the group believes they are identifying and meeting their needs to the extent desired. Responses to the evaluation indicate the support group is most helpful in (1) making new friends and (2) maintaining positive health behaviors. It also provided information on which activities best met which goals.

According to the results of the evaluation questionnaire (Appendix L), Goal 1--creating a supportive community--was best met by weekly exercises, healthstyle brags, informal socializing and group discussion. Goal 2--maintaining positive health behaviors--was best reinforced by weekly exercises, speakers and group discussion. Goal 3--empowerment--was indicated as being best met by weekly exercises and group discussion. Goal 4--skill development/transfer of leadership--was reinforced through group discussion.

The evaluation indicated that 100% of the respondents (N=11) had shared support group information with relatives and other people outside of the group. This is an indication that the participants have been gaining information they perceive as valuable. The act of sharing may be an indicator of their process of internalizing new health beliefs and behaviors, enhancing their own commitment to wellness.

Six people indicated that they participated in the first skill development workshop and found it useful. Also, seven respondents reported they have been helping conduct support group meetings. Six people indicated they would help plan and facilitate an ongoing support group including new graduates, and four more indicated they would like further practice and training.

When asked what they could do to improve the support group, the participants suggested: "nothing, I like it the way it is; more discussion and indepth handling of the subjects; more walks; new ideas to broaden the scope; develop role of outreach person for the group; interest more people in attending." The things the participants enjoyed about the support group included: "socializing and belonging to a community project; learning from speakers; participants and staff; friendly atmosphere; speakers, exercises and exchange of ideas; support like a family; learning new skills; the people and their interest in one another; helps keep up good life standards; fellowship and friendly objective members and support."

Attendance has varied from as many as twenty-five who turned out for a walk and picnic to as few as five, with an average of ten at weekly meetings. There is a core of about twelve committed people who have been attending regularly from the beginning. About six others were committed for a period of three to ten months, but then stopped coming due to busy schedules, changes in the meeting day and no longer needing the group. Out of forty-four graduates from the first wellness program group, twenty-eight have attended a support group meeting. The evening series of support group meetings was held for five months by graduates from the second program. These meetings were smaller in size, averaging five or six enthusiastic members, and were focused on continuing to learn more about wellness as a lifestyle.

About twenty graduates from the second group have been active as Wellness Advocates, either teaching wellness classes at the Wallingford Senior Center or elsewhere, or are acting as part of an unpaid support services staff for the Project. This type of volunteer activity might meet some of the same goals for these individuals as the support group does for others. Although both support groups were open to graduates from all program groups, there was minimal mixing between cohort groups.

Another way of evaluating the effectiveness of the Wellness Support Group is to consider the continuity and application of the five key concepts of the Wallingford Wellness Project. The first of these is health synergism embodied in a health promotion program that deals with the whole person. This has been carried on by the support group, and is evident in the group's planning tool where a review of past activities is related to future planning (see Figure 1).

The second basic concept is that of a supportive community which is, of course, the essence of a support group and is best illustrated by the growth and endurance of several group friendships. The atmosphere of the meetings is one of warmth and caring mixed with the spirit of enthusiasm which makes wellness contagious. As the participants experience this sense of community among themselves, they receive and provide the support which contributes to enhanced mental and physical health, meaning, and happiness in life.

FIGURE 1

A REVIEW OF WHAT WE HAVE DONE

PLANNING TOOL
USED BY THE
SUPPORT GROUP.

Exercise

* Yoga
* Tai Chi
* Aerobic Dance (3x)
* Rosalies Talk on Benefits

Stress Management

* Foot Massage
* Deep Breathing
* Memory Loss
* Co-counseling
* Coping with Hearing Loss

Nutrition

* Chef Chuck's Wok Cooking
* Good Food Inexpensively
* Dehydrated Foods
* Holiday Recipes
* Dr. Joel Konikow, Preventive Medicine Physician

Environmental Assertiveness

* Tilth and Urban Gardening
* Nature Walk
* Peoples Rights
* Greenpeace
* Puget Sound Health Systems Agency
* Foster Island Walk
* Clean Sound Coop

Skill Development

* Volunteer Orientation
* Skill Assessment
* Group Process Skills
* Planning Skills

Ongoing Training

* Leading Exercises
* Planning for each month
* Facilitating Discussions
* Planning the Exercise Group
* Coordinating Program Resources and Speakers
* Organizing the Holiday Party

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The third guiding principle of the project is that of participatory learning. The support group has continued with the model developed in the basic educational program. Members give presentations and demonstrations and have been integrally involved in the planning process to the point where they have assumed complete responsibility. Taking on this responsibility contributes to increased self esteem and recognition of one's capabilities. By trying out new or unused skills in a safe setting, group members continue to develop their health advocacy and leadership skills.

Another key goal of the project is that of perpetuation of the program after the funding ends. This goal was shared with the participants and given as one rationale for skill development and transfer of leadership. The staff believed this to be an ethically responsible objective on the part of a demonstration project that sets up expectations in the community at large. Health promotion classes in addition to the Wellness Support Group are being continued under the direct sponsorship of the Wallingford Senior Center. Further, wellness class participants in Bothell, Washington, a suburb of Seattle, led by WWP program graduates, have formed their own Wellness Support Group to continue their pursuit of positive health.

A final critical concept undergirding the other four concepts and design of the project, is that of empowerment. Empowerment is providing the opportunity for people to take charge of their lives, to act on behalf of their own and their community's best interests. This is essential to health. The Wellness Support Group offers an opportunity to continue to reinforce this principle. People learned how to take responsibility for their own health and to advocate on behalf of themselves and their community for a healthier, more humane environment and world. This concept is enhanced by the methods involved in participatory learning which values the skills and knowledge of all involved in the learning process. This concept is explicitly illustrated by the fact that the Wellness Support Group is in charge of itself.

CONCLUSION

The transition from primarily a staff facilitated to a participant facilitated program evolved over several months. This process involved explicit discussions and planning toward the goal of becoming self-sustaining and participant-directed. The planning included specifying goals, roles and

tasks in operating the group. A decision was made to rotate roles and tasks on a monthly basis. The following article which appeared in the WSC's June newsletter illustrates this:

WELLNESS SUPPORT GROUP

Wellness graduates have been meeting for eight months to support and encourage one another in continuing to strengthen their commitments to health enhancement. During the month of May, we evaluated our progress, heard about a different perspective on supertankers in Puget Sound, enjoyed a walk around Greenlake and held a get-acquainted picnic for new and former wellness graduates.

The plans for June include:

June 2	-	Open discussion/get-to-know new members session
June 9	-	Arboretum nature walk (meet at Senior Center 9:15 a.m.)
June 16	-	Open discussion/plan for July
June 23	-	Stress management including massage, breathing, guided imagery
June 30	-	Presentation given by representative of University of Washington Speech and Hearing Department.

Many members of the support group are involved in a variety of tasks and roles for the month of June. Erica Duringer will serve as the Outreach person and is available to give you information about the group, offer support, talk over concerns, and be someone you can call to let the group know if you are going to be absent for an extended period of time. Her telephone number is 527-5182. Rosalie Aschenbrenner will act as exercise leader. Jean Newman is helping with program arrangements. Group facilitators for June include Jean Newman, Della Patch, Bonnie Dewey, Lucylle Knudson, Erica Duringer and Rosalie Aschenbrenner.

Come enjoy and support your support group!

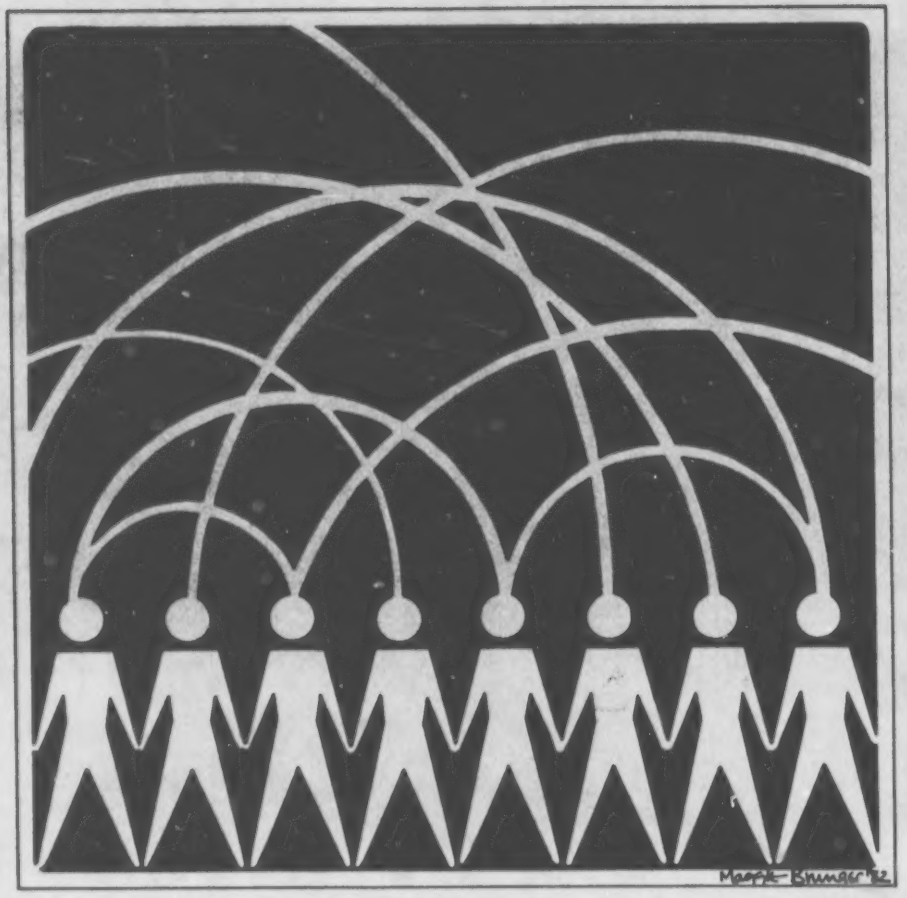
Finally, after having gone through a process of empowering themselves, Wellness Support Group members are now empowering others in their families, neighborhoods and communities. Wellness is indeed contagious.

REFERENCES

Katz, A., & Bender, E. The strength in us - Self-help groups in the modern world. New York, NY: New Viewpoints, 1976.

Lowenthal, M. Social isolation and mental illness in old age. In B. Neugarten (ed.), Middle age & aging. Chicago, IL: University of Chicago Press, 1968.

Silverman, P. Mutual help groups: Organization and development. Beverly Hills, CA: Sage Publications, 1980.



Transfer of Leadership and Management

Kelley Reid

"By letting go it all gets done;
The world is won by those who let it go!
But when you try and try,
The world is then beyond the winning."

Lao Tzu

A demonstration project has an ethical obligation to the community and to the funding source to plan and prepare for the day initial funding ceases. The transfer of program leadership and management was viewed as a means of meeting this obligation and played an integral part in developing and perpetuating the Project. It enabled us to responsibly meet community expectations and expressed need for services. Using non-paid workers to manage and implement health promotion activities also provided critical program support in a time of diminishing resources. This chapter includes a description and analysis of:

- the development of an ongoing relationship with the Wallingford Senior Center (WSC) which created a foundation for future programs;
- the training and work experience of wellness volunteers at the Senior Center and in the community; and
- the spontaneous growth of wellness activities beyond the Senior Center.

Two primary goals in implementing the transfer of program leadership and management were to pass information and skills from the academic community and the staff to participants and, through them, to the broader community and to establish an ongoing health promotion program in the WSC. A participatory approach was used to empower participants, tap their competence, nurture confidence, and give them a strong sense of ownership in the program and its outcome. The strategy of involving participants as leaders in the learning process reinforced the dual goals of passing

along to participants the most relevant information and skills possible and furthering the implementation of programs at WSC and elsewhere.

The flavor of the transfer process is captured best by self-reported data. This chapter relies heavily on participant comments, although individuals are not always directly quoted. In addition, evaluation data included written evaluations of teaching performance by Wellness Advocates, staff observations, meeting minutes covering the course of the Project, and one-on-one interviews with a sample of staff and participants.

RELATIONSHIP WITH THE WALLINGFORD SENIOR CENTER

The top priority of the staff, especially during the first year was to develop the research and program delivery components. As staff began to look at and work on the goal of transfer of leadership in the last year and a half of the Project, it became clear that a stronger relationship was required with the WSC. Although initial commitment to wellness programming was not a top priority, the WSC staff eventually became actively involved in accomplishing transfer of program management. Key chronological steps in this process are as follows:

1. The establishment of regular meetings between the WWP liaison person and the Senior Center Director;
2. The establishment of monthly reports to the Board;
3. The development of the Wellness Advisory Committee into a viable, self-facilitated entity (including a Wellness Speaker's Bureau);
4. The election of a Wellness Advisory Committee (WAC) member to the Senior Center Board of Management. This person agreed to serve as the "wellness" liaison to the Board in lieu of the staff person and to act as a representative of the WAC;
5. The formal adoption, by the Board, of a six-point proposal for ongoing wellness programming in the Senior Center (Figure 1) including the designation of the Wellness Advisory Committee as the "wellness subcommittee of the Wallingford Senior Center Board of Management;"

6. The hiring of an activities coordinator and social work intern assistant, both involved in health promotion, to coordinate planning and delivery of programs in WSC;

7. The training by the WWP staff of a group of volunteers including support services volunteers and teaching Wellness Advocates. Both groups received skills training and ongoing consultative supervision from the staff. Development of person-power resources for ongoing Senior Center wellness programming was a critical contribution;

8. The development by WSC staff, with WWP input, of a plan for ongoing wellness programming at the Center, to begin in January of 1982--including the organization and development of policy-making groups, the use of the Speaker's Bureau for recruitment of new participants, and other basic elements of program planning and delivery.

FIGURE 1

THE SIX POINT SENIOR CENTER RECOMMENDATION FOR WELLNESS AT WSC

(Accepted by the WSC Board July 20, 1981)

1. Incorporate wellness programming into the Wallingford Senior Center activities.
2. Use graduates of the Wellness Project to teach wellness activities.
3. Use the Senior Center's activities coordinator to schedule the classes, etc., and organize the volunteers to teach them.
4. Wellness classes will be available to seniors 55 years of age and older. (This was amended by the Center Board in December of 1981 to allow 20 percent of the wellness participants or 5 people, whichever is larger, to be under 55.)
5. The Center will raise the funds. (This is in reference to funds to support the activities coordinator's position.)
6. The Wellness Advisory Committee will be a subcommittee of the WSC Board with Ross Fritz serving as a liaison between the subcommittee and the Board. (Ross Fritz is a wellness graduate who was a member of the Advisory Committee and who served as liaison between that Committee and the WSC Board.)

The process of developing these steps is illustrative of WWP staff process and style. Although at times, plans seemed ambiguous and unstructured, the result of the transfer goal was a program owned and operated, at least in part, by the Wallingford Senior Center. At key transition points, however, we might have provided more guidance and consultation as well as a more formalized mechanism for communication. In order for WSC to assume leadership, it was important for us to gradually step back from ownership and direction of the program. This has been difficult for both the Wellness Advocates and WSC staff who, at times, felt abandoned to the sometime chaotic process of creative learning. It was difficult as well for the WWP staff to "let go".

VOLUNTEER LEADERSHIP DEVELOPMENT

Through skills training and class teaching, the staff helped to train participants as teachers so that they could utilize and pass on a participatory approach with those they taught. These Wellness Advocates were able to do this to varying degrees. Participatory approaches that proved to be particularly useful to these volunteers were: (1) class sharing of progress and problems; (2) participants choosing topics, speaking, and arranging presentations for the classes, especially Environmental Assertiveness; (3) discussion sessions using the following format: description of the general area to be discussed, facilitation of an exercise, recording of key concepts emerging from the group, supplementation with any concepts the group didn't produce; (4) reporting on books and magazine articles to the class; (5) use of small groups to generate discussion; (6) cooking demonstrations; and (7) stress management, physical fitness and assertiveness training exercises.

Benefits and difficulties of the WWP participatory approach, as identified by the Wellness Advocates, are displayed in Figure 2.

FIGURE 2

BENEFITS

1. It seemed to reduce class competitiveness experienced in other class situations.

2. People felt supported in making changes.

3. It drew on the experience and knowledge of the participants. This took some of the pressure off the teacher (which was especially important with many of the advocates who were afraid of failing if they had to be the "expert").

DIFFICULTIES

1. It sometimes felt "untidy" or confusing whereas a more didactic presentation would have been neater and easier to grasp (although a summation of the learning process at the end of a discussion helped alleviate this).

2. Some participants did not see the teacher as legitimate unless she/he was an "expert".

3. Participants sometimes didn't believe in the validity of their own experience and knowledge.

4. A minority of two or three people sometimes dominated the discussion.

5. For a low-income group at one of the sites, most of their energy was focused on survival issues which did not allow enough energy to help create a participatory learning environment.

6. Balancing discussion time and the need to move on to other issues on the agenda was difficult.

7. People expected to be entertained.

GROUP FACILITATION SKILLS TRAINING

Twenty-one individuals participated in the skills training. Almost all participants were graduates of the WWP. About half of them went on to teach in WSC health promotion classes. Several others teach wellness classes outside the WSC.

Six three-hour sessions were taught by Project staff over a three-week period. The intent was to teach a participatory facilitation style in a participatory manner. We sought to involve the learners in the experience of teaching, by focusing on planning, organizational, and process skills using the content of health promotion as a backdrop. Participants knew the basic information necessary to teach wellness, but came to learn how to organize and deliver this information in a participatory style. The session topics included:

- clarifying personal learning/teaching goals
- philosophy and values behind volunteering
- a basic introduction to the participatory learning model
- class planning: skills and procedures
- interpersonal communication skills
- group process skills
- psychosocial and physical aspects of aging and their relationship to effective facilitation of an intergenerational group including older adults
- problem solving: specific concerns.

A number of techniques were used to facilitate the learning process, often in the form of an experiential exercise preceded by a short didactic presentation of the material. In the first session everyone participated in a breaking the ice exercise. In subsequent sessions the group debated over choices for a mission statement for teaching wellness and decided to refer to themselves as "Wellness Advocates." And with the class planning session, small groups met together to actually plan their first wellness class. A common physical aspect of aging was explored by inserting ear plugs for part of a session. A lively discussion ensued regarding the effects of hearing loss on both teacher and learner and on what teachers could do to deal with this problem. The last two class sessions included realistic simulations of classroom experiences, feedback, and problem solving on specific concerns and fears about teaching.

The participants saw the training as effective and useful to their future teaching efforts. However, several participants felt there was not enough training time and left the sessions with strong doubts about their ability to teach. The staff has been available for continuing inservice training. Follow-up sessions were given on assertiveness training and group leadership skills. And social work practicum students have served as ongoing leaders which has helped to alleviate some of the fears experienced by novice group leaders.

OVERALL ASSESSMENT OF THE TEACHING EFFORT

To assess our training efforts and the skill levels of the volunteers, we interviewed seven teaching advocates and collected pre- and post-program written evaluations from eight. These advocates ranged in age from early twenties to mid-eighties. All had taught or were teaching at either the Senior Center or other sites. Improvements in program delivery, personal insights, and personal changes in behavior or perception were examined. A representative sample of comments from the interviews and evaluations is displayed in Figure 3.

A general picture of the overall improvements and challenges to advocates' teaching skills is apparent from Figure 3 and from the personal evaluation forms (Appendix M) filled out by Wellness Advocates. On the Likert scales, questions 1-10, there is only a slight increase in perceived improvement among the eight people filling out pre- and post-evaluation forms. The total pre-score is 589. The total post-score is 599. One possible explanation for this was suggested by a one of the advocates. She felt she was harder on herself with the second evaluation because she had a better idea of what she was doing wrong (i.e., she was a more sophisticated judge of her own shortcomings). The pre-answers are more general, simple, and sparse. The post-answers, on the other hand, are detailed, fairly complex and in-depth, reflecting a sophistication and understanding of necessary teaching skills that did not exist before the actual experience of teaching. One very positive result seen in this evaluation was that six people said they would commit themselves to teaching at least part time over the next year and two said they did not know. No one said she/he did not want to continue teaching.

FIGURE 3

AREAS OF ACHIEVEMENT

My awareness of health issues was raised.

My perceptions of individuals changed in a participatory model from seeing them as 'senile' to individuals with something to offer. I came to understand my own ageism better and to respect the elderly more.

We learned to work together better as a teaching team, to share our feelings, to plan better.

I learned to be more flexible.

We learned how to keep the interest level of participants up and how to involve them.

By putting in my own personal input, I helped make it more personal for others.

I don't worry. I do my best. I'm less of a crusader. Instead of miracles I'm satisfied with seeing small changes. I took it all too seriously at first.

The impossible became possible.

AREAS OF CONTINUING CHALLENGE

Ageism and sexism are very prevalent among the elderly. This was surprising and hard to deal with at first.

There was not enough time to plan and develop in-depth knowledge about the topics taught. This would have helped facilitate discussions richer in facts.

The use of forms detracted from the participants' feelings of empowerment, even when the forms were tools for creating their own personal change.

As I got more comfortable with the group, I got more sloppy about keeping track of time.

It's still hard to provide one program for a group with different skill levels.

We were frustrated with the lack of follow-up at home in terms of using the forms and making behavior changes.

Barriers to behavior change were: lack of support; too busy with other things; geographical handicaps; physical problems; it's boring; need to establish a routine.

It was frustrating to see people dropping out.

VOLUNTEER MOTIVATION

Over the last 2-1/2 years, over 100 people working more than 1,500 volunteer hours helped create the Wallingford Wellness Project. Why did these people volunteer; what did they find meaningful in the work they were doing; and, do they want to continue?

Volunteers who provided support services and those who taught classes identified the following reasons for volunteering: (1) a personal commitment to the empowering, growth producing aspects of wellness and wanted to share it with other people (one of the Wellness Advocates wanted to "bring about a new world order through people accepting responsibility for their health and behavior"), (2) felt they wanted to repay the Project for all it had done for them, and (3) believed that by teaching the content, it would improve their teaching skills and/or help with lifestyle changes they were trying to maintain or make themselves.

Responses varied considerably when asked whether they wanted to continue volunteering at the WSC after the demonstration Project ended. Time commitment necessary for effective teaching was seen as a major factor to consider. Support services volunteers in particular expressed a desire to continue to volunteer if their tasks as well as the time commitment could be very specific. It also seemed clear that the strongest commitment, for all volunteers, was to the WWP. But, as the volunteer coordinator put it so well, if they could be made to feel "special, needed, and unique," they would probably continue with the Senior Center.

From interviews with volunteers it is clear that they do not feel the program can be sustained adequately by volunteers alone. Reasons for this include: the need for someone to have an ongoing, sustained, and consistent commitment of several hours each day to devote to the amount of work involved in coordination efforts alone; need for an "inspirational leader"; and need for staff followup with ongoing groups like the Wellness Support Group.

We agree with this expressed need for paid staff with some professional background and experience. Professional staff can often do the job of coordinating more efficiently. Commitment and skills necessary for certain tasks like ongoing training and coordination of volunteers are critical. Paid staff are more likely to have an ongoing, consistent commitment. Professional staff are more likely to have the requisite skills in a variety of areas.

Ideally, what will evolve is a partnership between non-paid and paid staff which utilizes the best each offers. This partnership approach used by the WWP proved to be valuable in helping to improve the lives of older and younger participants in the Project. If a similar system is perpetuated by the Senior Center, it will help support not only wellness but all Center programming in a time of reduced funding. Over the last several months, wellness staff have been working closely with WSC staff to create such a system.

SPONTANEOUS GROWTH OF WELLNESS ACTIVITIES

One of the more exciting developments in the transfer of program leadership and management was the spontaneous growth of a number of different wellness activities outside WSC. In all of these cases, the individuals initiating the projects and classes received their training and the impetus to help others improve their healthstyles from the Wellness Project. Some are former staff members, others participated in the wellness classes and/or leadership training. What they went on to do outside the WWP was a result of their own commitment and belief in wellness. Some examples illustrate not only the empowering nature of what was created together but also the viability and growing acceptance of wellness as a lifestyle.

The Health Promotion With the Elderly Project, staffed by the WWP Director and two former WWP team members, has provided health promotion training (based on the WWP model) at regional workshops throughout the country. The Executive Director of SSC has made a personal commitment to starting Wallingford Wellness style health promotion programs in as many as possible of SSC's forty-two King County nutrition sites and senior centers.

An example of a classroom approach being offered outside WSC is provided by four Wellness Advocates who teach wellness classes in Bothell. These classes are held at the Northshore Senior Center and are so popular that the enrollment grew from 17 in the initial series to 25 people in a second series. Currently an ongoing support group of approximately 20 meet weekly.

Some other exciting contributions to wellness are the small scale contributions made by wellness graduates. Examples are the housewife who has shifted her entire family's eating habits towards a more healthy diet. Another woman is teaching a group of dental technicians, including

the one she visits, the effective use of stress management techniques with their patients. The director of a SPICE (Seattle Public Schools Involving the City's Elderly) site, where elders receive low cost meals and participate in a variety of programs, has begun to incorporate wellness activities into his programming. Another woman is teaching aerobic dancing in her home for people in the neighborhood. Two program graduates were motivated to return to graduate school to gain further knowledge and skills related to health promotion.

This spontaneous growth of wellness activity outside the WWP was especially evident at a final group skills training facilitated by staff at the end of March, 1982. In discussing how they were going to use this training it became clear that many of the 25 Wellness Advocates and potential advocates attending were moving on to additional health promotion work. Four advocates are teaching a group of Seattle school teachers how to teach wellness to their pupils. The Bothell group is planning to teach at yet another Senior Center. An advocate who had taught one series of classes at a low income community medical clinic is starting another series with plans to train some of these people as future trainers. And at least two advocates have secured paid social service positions where they are applying wellness principles.

CONCLUSION

Overall, the staff has successfully transferred major responsibility for leadership and management of this demonstration Project to the Wallingford Senior Center. In addition, we have been instrumental in establishing similar programs at other sites in King County and have disseminated information about the development and teaching of the WWP throughout this country and Canada.

Throughout, we have learned from our mistakes, as well as building on what went well. Clearly, we learned about the necessity of flexibility in implementing plans. We learned the necessity of building a strong foundation and relationship with the key organization involved in eventual transfer. We learned to value patience and the great satisfaction one can achieve through a succession of small accomplishments. We learned to do our work while letting go of what we created. We learned that an ongoing, solidly established program should not be "too solidly" established by those who initiate it. We found that trust in others' capabilities allows the creative, empowering process to bear the ripest fruit.

Evaluation Research

Bernadette Lalonde

How successful was our program in meeting the goals for which it was established? The question is an extremely important one--one whose answer may ultimately determine the worth of the program in the eyes of policy and decision makers, thereby influencing the funding future/fate of this and other health promotion programs for the elderly.

The question relies primarily on evaluation research for its answer. What is required is objective evidence of the effects of the program upon participants' health knowledge, attitudes, and behavior; evidence that the participants changed in a positive direction as a function of being exposed to our program.

It is the primary intent of this chapter to provide persuasive evidence of our program's effectiveness in promoting and sustaining health knowledge, attitude, and behavior change in persons over 54 years of age. In so doing, I hope to provide program evaluators, administrators, and service providers with basic knowledge and understanding of the evaluation research method--its necessity, its pitfalls, and some of the contrivances available for overcoming a veritable obstacle course of implementation difficulties.

THE EVALUATION RESEARCH METHOD

WHY BOTHER?

Several reasons exist. It is not my intention to exhaust the list of rationalizations in this chapter, but to present the more obvious reasons and to refer readers to Weiss (1972) for the complete tour.

Clearly, evaluation research is not for everyone or every project. Primarily, the process is designed to provide information for rational decision making. "Should this program be continued?" "Should that one be modified,

expanded, or deleted?" In an era of decreasing resources and increasing numbers of innovative social change programs, the questions become nightmares for decision makers with the decidedly difficult task of reallocating resources. Their decisions usually involve such large amounts of money and affect the lives of so many people, they are somewhat adamant about basing decisions upon something more than 'soft' evidence of program worth; 'soft' evidence being the testimonies and assertions of program staff and enthusiastic participants. After all, these parties have more than a passing interest in seeing their program continued. In addition, however, the argument is posed that subjective evidence of whether or not the participants enjoyed the program, preferred it lengthened or shortened, or whether or not the staff believed their program to be effective does not give decision makers objective evidence of the positive effects of the program upon the participants. Did they improve as a function of being exposed to the program? For better or worse, decision makers tend to throw hard scientific evidence into the balance when weighing the worth of the program. Ideally, it is the combination of research findings, testimonies of participants, and process evaluations made by program staff which allows wise, justified budget allocations and program planning decisions.

Decision and policy makers, however, are not the only ones to benefit from evaluation research. Consider program staff who 'know' their program to be effective because their professional judgement and the qualitative feedback from participants tell them so. Would they not benefit from research which has evaluated all components of their program to find one component more effective than the others in positively changing participants? This information might be of special interest if the component were scheduled for a major overhaul because the participants did not think it useful. Clearly, evaluation research can provide important, useful information for program development.

Obviously, when the future of a program has already been decided, where there is no question about program content or delivery, or where research evaluation is not going to have any effect on decisions, it may be an expensive, meaningless activity to conduct. There will be times, however, when you, the project administrator and staff, decide that no good reason exists to saddle your program with evaluation research, but then find the decision taken out of your hands. This is the age of accountability. The profession, consumers, and funding sources are demanding objective evidence of program effectiveness and safety.

Consider the program administrator of an innovative health promotion program which challenges and competes with traditional models of health for public and financial support. Administrator and staff may believe their program to be safe and equally or more effective in producing positive changes in health than traditional approaches, but public and private concerns tend to want more objective evidence of effectiveness before endorsing a program with either their money or their name. If your program is funded federally as a demonstration project, the decision to evaluate the program will again be made for you. Most demonstration projects now come with an evalution research component attached to them.

Obviously, these are but a few of the many reasons supporting the consideration of evaluation research activity. More comprehensive arguments are supplied by Weiss (1972).

WHAT IS THE METHOD?

Quite simply, the evaluation research method is very similar to the procedures of the classical experiment. The experimenter imposes strict controls over a number of variables or events thought to potentially affect outcomes so that the research results can be more assuredly attributed to the experimental procedure rather than extraneous circumstances. This is referred to as assuring the internal validity of the study; when the internal validity is high (i.e., all intervening variables are controlled) the experimenter is most confident that the observed effects of the experiment resulted from the procedures used. The experimenter compares the results of the experimental group to the results of a no-treatment control group which is similar to the experimental group in important characteristics. This is done to ensure that the observed effects are more a function of the experimental procedure than luck or chance.

Program evaluators attempt to do the same thing in their research evaluation. Basically, the method consists of the following steps:

1. Determining the goals of the program;
2. Translating these goals into measurable, explicit indicators of goal achievement;
3. Recruiting an experimental group and an equivalent control group;

4. Collecting similar data on at least two points in time on the experimental group exposed to the program and the control group not exposed to the program;

5. Comparing the data on the two groups in terms of the goals of the program.

Seem simple enough? Unfortunately, it is easier said than done. Program settings are real-life action settings and, as such, are very different from the laboratory settings in which the classical experiment lives and thrives. More often than not and because of this difference, action-setting evaluators are forced to make numerous compromises between research ideals and program realities. The net result is often the reluctant abandonment of traditional experimental design with its rigorous control of all threat to internal validity, and the acceptance of the less rigorous but perfectly legitimate quasi-experimental designs which allow concession for a number of implementation difficulties. Weiss (1972b) takes a hard look at these difficulties and discusses ways and means of going around them, through them, and over them. The most hazardous of the stumbling blocks, the potential misalliance between evaluator and program personnel, is given special mention here. The shallower pitfalls are discussed in the next section in the context of the Wallingford Wellness Project's (WWP) evaluation.

THE FIRST HURDLE

Do not expect program personnel to welcome evaluation research or the evaluator with open arms. One asks too much, for the evaluator comes asking questions about program worth and looks for 'proof' when staff often 'know' their program to be effective. The evaluation is sometimes considered to be inappropriate, unnecessary and threatening to the existence of the program. It is common knowledge in most social service fields (refer to Elinson, 1967) that even the most competently conducted evaluation research projects tend to yield few or no significant results. If the people holding the purse strings consider only these results in determining the worth of a program, the program's future becomes a contradiction in terms, and the program staff have the grim task of finding other employment. This alone would suffice to legitimize dissonant feelings often found between program personnel and evaluators, but there are other reasons. The staff's primary role is to provide service; the evaluator's is to collect objective proof of effectiveness through research. Already there is a conflict of interest. Personnel may consent to take time out from their duties to

hand out and collect the evaluator's reams of paper work, provided the research does not drastically interfere with their program's development. Unfortunately, research requirements tend to do just that. As will be discussed more fully later, program staff, to their credit, are constantly trying to improve their program. Research requirements dictate the program not be changed while the evaluation is underway. Needless to say, dissension grows well in this environment of conflicting interests.

What can be done? Fortunately, administrators, evaluators, and staff can do a great deal to promote a healthy, productive alliance between research and program personnel. First of all, administrators are encouraged to hire the evaluator as close as possible to the beginning of the project and have her/him actively involved in both the program development and the research activity. In this way, the evaluator may serve to gain understanding and empathy for the needs of the program, and the staff for the requirements of the research. It is important to promote staff acceptance of research activity. What better way to do it than to have them actively involved in the research effort from the very beginning? It would be wise to hire an evaluator from a social science background for the same reasons. This helps ensure that her/his frame of reference, interests, values, and goals are at least similar to those of the program staff. And, of course, evaluators should have considerable experience with social science research design, methodology, and analyses.

Staff and evaluator have the important task of developing a rapport with each other, gaining an understanding and respect for the other's responsibilities, and keeping the lines of communication open. Ensuring that the right hand always knows what the left is doing, and why, will avert many problems and may allow program and research activities to live in relative harmony.

RESEARCH EVALUATION OF WWP

At this point, I wish to turn to the primary purpose of this chapter--to provide our funding source with research evidence of our program's effectiveness. WWP was funded as a reseach and demonstration project by the Administration on Aging. As such, it was charged with two main objectives:

1. To develop, implement, and refine an effective health promotion program for the elderly;

2. To provide evaluation research evidence of the program's effectiveness.

The program staff have addressed the activities involved in meeting the first objective in the preceding chapters; I address the second objective here. Please note at this time that the preceding chapters refer to several program revisions and three or four groups of participants. Due to time and resource constraints, evaluation research was collected on only the first two cohorts, involving two experimental groups and two comparison groups. No mention will be made, therefore, of the third and fourth cohorts in this chapter. Also, please note that participant numbers and age range may vary between this and other chapters. In the research we were primarily interested in persons over 54 years of age. Statistics in this chapter reflect this constraint. Also, if someone completed our pretest questionnaire, they were considered to be part of the research even though they may have dropped out of the program at a later date. Other chapters tend to reflect the number of people, regardless of age, who actually participated in and graduated from the program.

As mentioned earlier, a number of research-program compromises are inevitable when one attempts to fit an action-setting program into a rigid research design. In the discussion of WWP's evaluation research method and results, I will take time out to illustrate compromises as they occurred in the process, and will comment upon what could be done if we had it all to do again. Valuable knowledge and experience have been gained in this evaluation process providing hindsights which may prove beneficial to other program administrators, evaluators, and staff.

GOALS OF WWP

The first step in the evaluation research method is the determination of and consensus on the goals of the program. This is no easy task: the goal may be too global, or impossible to measure via any instrumentation; there may be multiple goals, some in direct conflict with others; administrators and staff may not agree upon the goals, or on how to prioritize them. One must simply persevere at this time for it is essential that the goals of the program be explicit, that they be capable of translation into measurable indicators of goal achievement, and that administrators and staff agree upon the goals and their measurement.

WWP staff defined an effective health promotion program as one which would maintain and/or improve the mental, social, and physical health of participants. They agreed the program would be intergenerational in design, and realized that the program would need to accomplish several things to successfully meet the defined goal. It would need to:

1. Increase participants' health knowledge or information;
2. Increase motivation and confidence to change long-standing unhealthy lifestyle habits;
3. Promote self-acceptance of responsibility for health;
4. Initiate and sustain positive behavioral changes in nutrition, stress management, physical fitness, and environmental assertiveness.

These, then, were the immediate and intermediate goals of the program. It was hoped, however, that these changes would ultimately result in the following long-term effects:

5. A decrease in morbidity rates (the number of days of reduced or restricted activity due to sickness or disease);
6. A reduced reliance upon social and health services as evinced by a reduction in the number and length of confinements to mental and health institutions (e.g., nursing homes, hospitals), number of doctor visits, and number of mental health counselor visits;
7. A decrease in the number of chronic health problems reported by participants;
8. A decrease in the number of prescribed medications for this age group.

Although the program staff were optimistic about their program's potential to meet these latter goals, we were not confident the effects could be observed in the evaluation period. It was predicted that it would take longer than one year--the length of our evaluation period--before these behavioral implications could be evinced in the data.

PROGRAM DESCRIPTION

The program has been described in detail in preceding chapters, but a brief review may prove useful. The program offered education and behavior change training in four main health areas known to affect wellbeing in everyday life: exercise/physical fitness (PF), stress management (SM), nutrition (N), and environmental assertiveness (EA). Originally, the program consisted of 24 weeks of class, 3 hours per week, where physical fitness, stress management, and nutrition were each taught for 8 consecutive weeks, along with environmental assertiveness which ran for the entire 24 weeks (Figure 1). Through ongoing process evaluation made by participants and staff, the program was later refined to 21 weeks where each class was taught for 7 consecutive weeks. A short discussion of this action follows the program description as it exemplifies one of the compromises to which evaluators generally have to bow down.

FIGURE 1

CLASS TIMELINE

Physical Fitness (8 weeks)	Stress Management (8 weeks)	Nutrition (8 weeks)
Environmental Assertiveness (24 weeks)		

The classes were co-facilitated by 2 of 5 professional staff (2 males, 3 females) including two graduate student interns from the University of Washington School of Social Work. Classes were kept small (10-20 per class) to facilitate the preferred group learning approach to instruction. This meant that the experimental groups were divided into several subgroups, based upon participant class time preference. Staff were rotated through the groups to control for effects which might have been related to individual teaching style or sex of facilitator. The order in which class components were taught (i.e., SM, PF, N, EA) varied between groups to control for order effects.

At this point, I return to the compromise alluded to earlier. It results from the basic conflict which exists between the requirements of research and the needs of the program. Experimental research requires that the program

remain stable over its course in order to gain a clear understanding of what program components were responsible for which observed effects. This means that staff should not change, improve, refine, or in any way meddle with the program once it is underway. They often do, however, with and without the evaluator's prior knowledge, and for some of the best and worst reasons. Program staff tend not to consider research their first priority. Their first concerns are to develop an effective program and to provide good service. Their ability to do either is severely limited if they are not allowed to improve upon their program as they go along, incorporating feedback from participants and other staff. Is it not unreasonable to expect them to wait until the program and the research are over before improving obvious program deficiencies? It is, and they won't! When there are conflicts or interest between research requirements and program needs, the program will generally win.

This may do nothing for the evaluator's mental health or the experimental design, but it need not blow one or both away either. Oftentimes the changes are small improvements in teaching style, the cleaning out of redundant materials, the condensing of class materials--none of which seriously jeopardize the research effort. Fortunately, this was the case with WWP. The program was refined from 24 to 21 weeks as a function of the changes just mentioned, but also as a function of class facilitators simply becoming more experienced, comfortable, and competent in their roles. The core components of the program were not changed, the format remained the same, and basically the same skills and information were imparted throughout the project.

Other evaluators may have more difficulty. Evaluators are often asked to evaluate a program prematurely, before the major development process is over. Trying to keep program delivery steady for evaluation purposes while the staff are still actively developing it presents a major challenge to the evaluator. If the staff want to/need to drastically change their program midstream, and if they tell the evaluator of the changes before they are implemented, she/he may be able to cajole, convince, or threaten the staff into confining the changes to one group. In WWP, for example, we saved most of our program changes until the interim period between groups; i.e., the first group completed the program before changes were made and the program offered to the second group. Not only did this help preserve the integrity of the design, it allowed the added opportunity of comparing the effects of the refined program with the effects of the original program.

RECRUITMENT

The program was advertised via various media including newspapers, radio announcements, and group presentations. Two experimental groups were recruited from respondents (the first group received the original program, the program was revised slightly, and then offered to the second group). Anyone requesting inclusion into the program was granted admission provided they were physically capable of participating in the classes at the Senior Center where the program was housed. A health screen questionnaire listing current medical problems and medications was completed on each person in the experimental groups. Persons with major health problems were encouraged to obtain medical clearance from their health care providers before participating in the program. No one, however, was refused admission into the program if they failed to comply with this request. Two comparison groups were recruited from neighborhood church groups, social groups, and senior housing complexes.

As recruitment generally poses another research problem, allow another diversion to point out our problems and what we did about them. The hitch is that stringent experimental design requires controls to be very much like the experimentals (i.e., participants) before the program begins. Consequently, both groups should be drawn from the same population pool and then randomly assigned to either the experimental group or the control group. Program evaluators, however, very seldom find themselves in the luxurious position of being able to randomize assignment to groups. The reasons are many: the voluntary nature of the recruitment process, insufficient numbers of people interested in the program, ethical considerations of withholding service from persons who want it or need it.

An alternative is to match participants and controls on characteristics thought to be relevant to program outcomes. In our case, these characteristics (referred to as the independent variables) were age, sex, race, socio-economic status, marital status, and health levels. A true match procedure, however, also requires large numbers of interested persons; here is the rub. Experimental participants are not too difficult to recruit because they stand to gain something from their involvement. Control groups are another matter entirely. We ask them to commit time and energy, yet give them relatively little in return. Hence, they are very difficult to recruit. Although we promised each of our participants and controls a five dollar reward each time they completed and returned our questionnaire,

promised all interested parties a copy of the research results, waxed lyrical about the necessity of a control group to the program and research efforts, and generally lavished them with gratitude and appreciation, we were still unable to recruit enough controls to allow the selectivity or rigorous matching activity preferred.

To control for socio-economic status and race, WWP staff recruited both the experimental and control groups from the same geographic locations. And, whereas we were mindful of the need to match the groups as closely as possible in terms of age, sex, marital status, and health levels, recruitment difficulties led us to accept anyone living independently in the community who would consent to be in the control groups. In an experimental design any control group is considered to be better than no control group at all. In situations where a true match cannot be made, the control groups are generally referred to as comparison groups in deference to the non-selective procedures to which one must yield. Analyses later revealed our experimental and comparison groups to be indeed matched in terms of age, sex, socio-economic status, marital status, and health levels.

Although the classes were fully age integrated, meaning program participants ranged from 13 to 87 years of age, we were most interested in evaluating the impact of the program upon persons over 54 years of age. This was, of course, our prime objective. Research data, therefore, were only collected on persons over 54 years of age in the first experimental and comparison groups (N=47 and 48 respectively). In the second experimental and comparison groups data were collected on all participants, regardless of age, in order to investigate the possible effects of the program on younger populations as well. Priority remained, however, with persons over 54 years of age. In the second experimental and comparison groups, these persons numbered 90 and 44 respectively. Table 1 provides descriptive statistics on persons over 54 years of age in each of the four groups.

TABLE 1

DESCRIPTIVE STATISTICS ON SUBJECTS
OVER 54 YEARS OF AGE

	Exp 1	Comp 1	Exp 2	Comp 2
Total N	47	48	90	44
Age Range				
Low	60	57	55	61
High	83	93	87	98
Mean Age	71	74	70	73
N of Males	10	14	19	10
N of Females	37	34	71	34
$\bar{X}$ Yearly Income	8,487	10,724	11,866	9,792
Marital Status				
Married	22	17	38	15
Widowed	13	21	34	25
Separated	1		1	
Divorced	4	6	8	4
Single	7	4	9	

MEASUREMENT

A questionnaire was composed to include both established measures of health found in the literature and measures developed specifically for the project. Although aware of the advantages in using only tried and tested measures of respectable validity and reliability found in the literature, the staff were forced to undertake the arduous process of developing some of their own measures of health information, attitude change, and behavioral change; the literature search did not yield any adequate measures in these areas. The questions developed by the staff were pretested with the first cohort and revised for the second cohort.

The developed questionnaire had four parts, was quite lengthy and involved, and required a trained interviewer to spend 1-2 hours with each subject to complete parts I and III of the questionnaire, and an additional 1-2 hours of the subject's time to complete parts I and IV. Apart from a host of demographic questions (e.g., age, sex, marital status), the questionnaire included the following:

- The Sickness Impact Profile (Bergner et al., 1981): a 93-item scale providing single and composite measures of physical and psychosocial dysfunction;
- The Rand Mental Health Index (Brook et al., 1979): a 46-item scale providing measures on anxiety, depression, positive wellbeing, emotional ties, emotional stability, and a composite mental health index score;
- The Rand Social Health Index (Brook et al., 1979): an 11-item scale measuring group participation, social contacts, and total social health;
- Some of the Stanford Heart Disease Prevention Program's health knowledge questions and risk factor analyses scale, the latter measuring susceptibility to heart attack and stroke by investigating behavioral indices such as amount of salt, fat, and cholesterol in the diet, weight, smoking habits, amount of stress experienced;
- Attitudinal indices toward physical status and health behavior, such as self-ratings on health, self-responsibility for health, motivation and confidence in ability to initiate and sustain healthy behavioral lifestyle changes;
- *Health behaviors such as the number of physician visits in the past year, morbidity rates in the past six months, the number of health problems reported, the number of medications prescribed;
- *One day diet survey;
- *Blood pressure readings;
- Height and weight.

If we had it all to do again, we probably would not include the instruments indicated with an asterisk. Why not? Firstly, the evaluation period was too brief to capture changes in long-term health benefits such as morbidity rates, utilization of health services, and decreases in prescribed medications. Secondly, one day diet surveys have not been found to be reliable; people tend to report what they think they should have consumed in any one day, not what they actually did eat. Or they select a very atypical but healthy diet day to report. One could increase the reliability of the diet survey by using a one-week diet survey, that is if one could cajole subjects into doing this. That leaves two other problems with diet surveys. They are extremely difficult to analyze (possible, however, with the help of a dietician and diet research experts) and notoriously difficult to implement.

No matter how long one lectures on the importance of specificity (e.g., 6 oz. skim milk, 8 oz. coffee with 1 tsp. white sugar), the majority of returned surveys will be consistently non-specific (e.g., milk). At last of all, blood pressure readings fluctuate daily and require some expertise in obtaining reliable readings. Unless interviewers have had extensive experience taking blood pressures (ours did not) the reliability of the readings remain suspect.

My advice to other program planners and/or evaluators would be as follows: (1) ensure that the evaluator is involved in questionnaire development; (2) where at all possible, rely on measures reported in the literature which have been tried, tested, and found to have respectable reliability and validity quotients; (3) if you have to develop a new measure, conceptualize it carefully, develop it with consideration to issues of validity and reliability, and pretest the questions on a pilot group; and (4) keep the measurement short and appropriate to the goals of the program. Long questionnaires tend to irritate the people who have to fill them out, they promote subject attrition, and they try the patience of the most even-tempered interviewers. In addition, long questionnaires tend to yield too much data, thereby making the evaluator's job of data interpretation that much harder.

DESIGN

The favoured design for evaluating the effectiveness of a health promotion program would be one which obtained measures on all the dependent measures (e.g., health knowledge, attitudes, behaviors, and other variables one wishes to change via the program) for both the experimental and comparison groups at several points in time: (1) before the experimental group participated in the program (pretest); (2) immediately after the experimental group graduated from the program (post-test); and (3) six and twelve months following the experimental group's graduation from the program (follow-ups). In this way, one could more assuredly attribute the changes made by the experimental group, which were not made by the comparison group, to the effects of the program rather than extraneous circumstances, luck, or chance. As some behavioral changes may take months before they are evinced in lifestyle, the design allows for 2 follow-ups which should provide enough time to reliably measure change in these variables.

Obviously, we would have liked to have employed this experimental design with WWP. Unfortunately, logistics of time, personnel, budget constraints, and the serious threat of subject burnout which would result in high attrition would not allow a full experimental design. A quasi-experimental design was adopted in which the questionnaire was administered to all groups before the experimental groups participated in the program. Parts I and III of the questionnaire were completed by a trained interviewer (male and female graduate students from the University of Washington, trained in interviewing technique by the evaluator) during face to face interviews with subjects. The interviews were conducted at either the subject's home or other private place agreed upon by both parties. Parts II and IV of the questionnaire and the one day diet survey were left with subjects for completion and immediate return by mail in the self-addressed, stamped envelopes provided. A slightly revised version of the questionnaire (with unnecessary questions such as age, sex, and race removed) was then administered, depending upon the group, either immediately following the end of classes and 6 months following graduation from the program, or 6 and 12 months following graduation from the program (Table 2).

TABLE 2

RESEARCH DESIGN

	Pretest	Program Participation	Immediate Post-test	6-Mth. follow-up	12-Mth. follow-up
1st Exp	Yes	Yes (24 wks)	--	Yes	Yes
1st Comp	Yes	--	--	Yes	Yes
2nd Exp	Yes	Yes (21 wks)	Yes	Yes	--
2nd Comp	Yes	--	--	Yes	

Although a full experimental design may be considered to be more powerful in the validity of the inferences that can be made about the effects of the program, this quasi-experimental design had the distinct advantage of being both practical and feasible. A highly controlled experimental design simply could not be implemented successfully in this situation. Contrary to some belief, quasi-experimental designs are not sloppy experimental designs, but legitimate,

controlled designs with logic and form of their own. Readers are again referred to Weiss (1972) and the highly respected research design experts, Campbell and Stanley (1963), for endorsements of this type of design.

ANALYSES AND RESULTS

The Student t-statistic or chi square for categorical variables was employed to examine the comparability of the participants and comparison controls prior to the start of the program. Comparing each experimental group with its comparison group, the groups were found to be comparable at the time of pretest in terms of age, sex, socio-economic status (as measured by yearly income), marital status, and health levels (as measured by the Sickness Impact Profile, Bergner et al., 1981). Comparing the first experimental and comparison groups with the second experimental and comparison groups, the second groups were found to be less healthy than the first groups at the time of pretest. This confirmed the staff's suspicions that the first advertising campaign for the program attracted older persons who were relatively healthy. Because the second groups were less healthy at the time of pretest, and because they received the refined version of the program (21 weeks of class), we were particularly interested in the results relating to the second experimental and comparison groups. In many ways, the first experimental and comparison groups could be considered part of our pilot study. All findings, however, are reported.

Before presenting these findings, allow a word about interpretation of the data. Only results significant at the .01 alpha level are reported in the tables. Because of the exploratory nature of the study and the large number of variables investigated, we run the risk of finding significant results simply on the basis of chance. To minimize faulty interpretation we abandoned the normally used .05 alpha level of significance in favor of the more stringent .01 alpha level.

Employing the Student t-statistic and comparing scores on the dependent measures between the first experimental group's pretest and 6-month follow-up scores, the first experimental group was found to have significantly improved scores ($p < .01$) on health knowledge and health information (Table 3). The health knowledge variable represents participant scores on the questions adopted from the Stanford Heart Disease Prevention Program; the health information variables represents the score to questions specifically designed for our program, including questions on stress

management and environmental assertiveness not included in the Stanford questions. Motivation and confidence in ability to initiate and sustain positive behavioral changes in lifestyle were also significantly improved. At the 6-month follow-up, the first experimental group also showed a greater acceptance of responsibility for their health, as opposed to assigning primary responsibility for their health to doctors, other health care providers, family members, or friends. These significant changes were still prominent at the 12-month follow-up. No significant additional improvements were made on the dependent variables between the 6 and 12 month follow-ups. In addition to maintaining the improvements made from the time of pretest to the time of the 12-month follow-up, the first experimental group showed significant improvements in group participation (as measured by the Rand Social Health Index) and awareness of available social and health services. These improvements were not evinced at the 6-month follow-up.

The first comparison group, by contrast, showed only a significant increase in health knowledge (the Stanford questions) at the time of the 6-month follow-up (Table 3). This suggests that the improvements made by this group and the experimental group in health knowledge were not so much a function of our program, but perhaps practice effects of answering the questionnaire more than once, increased coverage of diet and exercise topics by the media, or one of many other possible reasons. Surprisingly, the first comparison group, in contrast to the first experimental group, showed significantly reduced systolic and diastolic blood pressure readings and reported fewer health problems at the time of the 12 month follow-up than they did at the pretest. The blood pressure results may or may not be an artifact of non-medically trained interviewers taking the blood pressures. As many of the subjects in the first comparison group were also members and participants in a senior center with a traditional health care component, it is also possible that the blood pressure finding demonstrates the benefits of this senior center's hypertension control program. No obvious reason exists for the reduction in reported health problems--other than social desirability (i.e., the need to 'look good' to the experimenter and less than truthful reporting of health problems). One might argue that the experimental group may not have felt this need, having developed a very open, honest relationship with program staff.

TABLE 3

FIRST COHORT

SIGNIFICANT FINDINGS ($p < .01$) AT

THE 6- AND 12-MONTH FOLLOW-UPS

6-Month Follow-up		12-Month Follow-up	
1st Experimental	1st Comparison	1st Experimental	1st Comparison
Health Knowledge	Health Knowledge	Health Knowledge	Health Knowledge
Health Information		Health Information	
Motivation/ Confidence		Motivation/ Confidence	
Responsibility for health		Responsibility for health	
		Group Participation	
		Social and health service knowledge	Social and health service knowledge
			*Blood Pressure
			*Health Problems

* Decreases

Analysis of variance was conducted to investigate whether the experimental group changed significantly more or less than the comparison group on the health knowledge variable. This analysis did not yield any significant difference between the groups although the trend favored the experimental group. Analyses of variance were also conducted to examine the effects of sex on each of the dependent variables. No significant results were found at the .01 alpha level.

Comparing the second experimental group's pretest and immediate post-test responses for persons over 54 years of

age (Table 4), significant improvements were found in comparative social health (i.e., where participants rated their social health in comparison with persons of similar age), mental health, positive wellbeing (both measured by Rand), and motivation and confidence in ability to initiate and sustain positive behavioral changes in the areas of nutrition and stress management. They did not show significantly improved motivation and confidence in the areas of environmental assertiveness or physical fitness, although the trend was in the direction of improvement. Significant positive behavioral changes were found, however, in all the four health areas of PF, N, SM, and EA. Significant increases were also found in participants' health information related to SM and EA, but not PF or N. Again, however, the trend was positive in these areas, and significant at the .05 level. And, finally, a significant reduction was found in risk to heart attack and stroke, as indicated by the Stanford risk factor analysis questions which measure changes in diet, smoking, physical exercise, and stress levels.

As shown in Table 4, the majority of these changes were sustained over the 6-month follow-up period although no additional change was made in any of these variables during the post-test-6-month follow-up period. Of the changes not sustained at the .01 level, many were found to be significant at the .05 level. The 6-month follow-up data also revealed a significant decrease in depression, an increase in responsibility for health, and an increase in knowledge of available social and health services. This latter increase in knowledge was not accompanied by an increase in service utilization. No sex effects were found on any of the variables at either the immediate post-test or 6-month follow-up.

As mentioned earlier, immediate post-test data were not collected on the second comparison group. Comparing pretest and 6-month follow-up scores for this group, the data revealed that the second comparison group, like the experimental group, did experience positive increases in overall mental health and positive wellbeing. Analyses of variance investigating whether the experimental group changed significantly more or less than the comparison group on any of these variables did not yield any significant differences. One must conclude, therefore, that the changes experienced by the groups on these variables were not a function of being exposed to our program, but extraneous circumstances. Surprisingly, and for no obvious reason, the second comparison group reported a significant reduction in the number of medications prescribed to them. In contrast to the experimental group, however, they did not show any significant

improvement in health information, motivation/confidence, health behavior, depression, or responsibility for health, not even at the .05 alpha level.

TABLE 4

SECOND COHORT (OVER AGE 54)
SIGNIFICANT CHANGES REPORTED AT THE
IMMEDIATE POST-TEST AND 6-MONTH FOLLOW-UP ($p < .01$)

Immediate Post-test[1]	6-Month Follow-Up	
2nd Experimental	2nd Experimental	2nd Comparison
Comparative Social Health		
Overall Mental Health	Overall Mental Health	Overal Mental Health
Positive Wellbeing	Positive Wellbeing	Positive Wellbeing
Motivation/ Confidence (N,SM)	Motivation/ Confidence (N)	
Behavior Changes (PF,N,SM,EA)	Behavior Changes (PF,N,SM,EA)	
Health Information (SM,EA)	Health Information (EA,N)	
*Risk Factors	*Risk Factors	
	*Depression	
	Responsibility for Health	
	Social and Health Service Knowledge	Social and Health Service Knowledge
		*Number of Medications Prescribed

[1] Immediate post-test data were not collected on the second comparison group.

* Decreases

As shown in Table 5, many of the same changes found in persons over 54 years of age were also found in participants 54 years of age and under at the time of the immediate post-test and the 6-month follow-up. Analyses of variance established that neither group changed significantly more or less in terms of these variables (e.g., both those over 54 years of age and those 54 and younger showed significant improvements in their behavior related to PF, but one group did not change more than the other). Some interesting between group differences were found, however, such as a significant decrease in anxiety found in persons 54 and under, but not persons over 54 years. Table 5 does not show sustained improvement in either overall mental health or anxiety at the 6-month follow-up. Improvements were made, but were significant at the .05 level rather than the .01 level. Again, no significant sex effects were found.

TABLE 5

SECOND EXPERIMENTAL GROUP (UNDER AGE 55)[1]
SIGNIFICANT CHANGES FOUND AT THE IMMEDIATE
POST-TEST AND 6-MONTH FOLLOW-UP ($p < .01$)

Immediate Post-test	6-Month Follow-Up
2nd Experimental	2nd Experimental
Overall Mental Health	
*Anxiety	
Motivation/Confidence (N)	
Behavior Changes (PF,N,SM,EA)	Behavior Changes (PF,SM,EA)
Health Information (EA)	Health Information (SM,EA)
*Risk Factors	*Risk Factors
	Responsibility for Health
	Comparative Social Health
	*Health Problems

[1] Results on persons 54 years of age and under in the second comparison group are not reported as only 4 persons were in this age range; the validity of the findings are greatly reduced with such a small N.

* Decreases

DISCUSSION

Much of this discussion centers on the findings related to the second cohort. Because both the program and the questionnaire were still in an exploratory and draft stage at the time of the first groups' evaluation, the first cohort is considered to be our pilot study. Several important findings, or lack of them, pertaining to the first experimental group deserve some discussion however: the lack of behavioral changes, and the strengths of the unrevised program in promoting and sustaining important attitudinal changes toward health.

The lack of behavioral change in the first cohort at both the 6 and 12 month follow-ups is probably more a function of the first experimental group's relative good health upon entrance to the program, rather than program ineffectiveness in promoting these changes. The Sickness Impact Profile confirmed the second experimental group to be less physically and psychosocially healthy ($p < .01$) than the first experimental group at the time of pretest. In addition, the Stanford risk factor analyses, measuring susceptibility to heart attack and stroke by looking at behavioral indications found in the diet (e.g., the amount of salt, cholesterol, and fat consumed), physical activity, smoking behavior, and stress level, indicated that the first experimental group was significantly less prone ($p < .01$) to risk of heart attack and stroke than the second experimental group at the time of pretest. These findings suggest that the first experimental group was probably practicing relatively healthy lifestyle habits before entering our program and, therefore, stood to gain less from the program in terms of behavioral change than the second experimental group. We were, however, very pleased to see that the program was effective in increasing the first experimental group's health information scores, increasing their overall motivation and confidence to sustain their good health habits, and generating a greater acceptance of responsibility for health. Moreover, these positive changes in attitude and information were sustained over the 12-month follow-up period. These results are particularly encouraging when one realizes the challenge involved in merely maintaining good health levels among the elderly. WWP's original program accomplished this, but was also instrumental in promoting positive change in participants.

The results pertaining to the second cohort (age > 54) were even more encouraging. The program was found to be effective in promoting and sustaining information, attitude, and behavioral change in persons 55 years of age and older. None of these changes, were found in the second comparison

group, not even at the .05 alpha level. Whereas all program components (e.g., PF, SM, N, EA) were found to be effective (p=.000) in promoting and sustaining positive behavioral change in lifestyle habits, some components were found to be more effective than others when it came to information and attitude change. These findings should be of particular interest to other program staff contemplating or in the process of developing a similar health promotion program for the elderly. For example, all our class components served to significantly increase health information in PF, EA, N, and SM at the .05 alpha level, but only the SM and EA components were found to be effective in producing significant change in health information at the .01 level at the immediate post-test. Only the increase in EA information was sustained over the 6-month follow-up period. Other program staff may wish to study the less effective components and devise ways and means of increasing their effectiveness in imparting health information. The same may be said for improving individual component effectiveness in increasing motivation and confidence. Some caution should be exercised, however, in changing WWP components to facilitate a greater impact upon health information, and motivation and confidence. The components, as they stand, have been shown to be very effective in promoting behavior change regardless of whether significant changes were made in information and confidence or not. The argument may be presented that behavior changes are the most important indicators of goal achievement for this type of project. Theory and research tend to suggest that it is behavioral change in lifestyle habit which will ultimately affect the incidence and severity of chronic illness in our older citizens, not change in health information or confidence levels.

At this time mention must be made of the many results which indicated mental, social, and physical health improvement in both the first and second experimental groups; results which were not found to be statistically significant at the .01 alpha level, but still indicated positive change which was not experienced to the same extent by the comparison groups.

The findings also suggest the program to be effective in promoting health information, attitude, and behavior change in younger populations (age <55) as well. It would appear, however, that the program was slightly more effective for older populations for the program did not serve to sustain motivation and confidence increases in persons under 55 years of age, whereas it did for persons 55 years of age and older. It also did not sustain behavior change in lifestyle habits

relating to diet in the younger population group, whereas it was effective in sustaining this change in our older population. It is also interesting to note that the program was effective in significantly reducing anxiety in younger populations at the immediate post-test, whereas this effect was not demonstrated in our older group. This may or may not be a function of older persons having very realistic and legitimate fears concerning reduced incomes, the serious effects of chronic disease, and fear of death. These fears and anxieties may not be easily allayed by any program.

In summary, the evaluation research established WWP to be effective in promoting and sustaining increases in participants' health information, positive attitudinal changes toward health, and in instrumenting important behavioral changes in lifestyle habits. Given that 24 or 21 weeks is not a long period of time to impact upon a lifetime of attitude and behavior, we are more than pleased with these results. We are doubly pleased when one considers how many research evaluations do not yield significant results, no matter how competent the evaluation or how wonderful the program. Evaluation research typically terminates with data reduction and statistical analyses of the change between the experimental and comparison groups. One must remember that group analyses does not reflect individual change, it reflects the average change between groups. This change must be substantial and consistently in the same direction for the majority of participants in each group before the between group change is computed as being statistically significant. With this in mind, WWP must be considered a very effective program since group analyses revealed change at even the stringent .01 alpha level. These objective results support and substantiate the subjective evaluations of the WWP staff and the testimonies of the participants.

We are neither surprised nor discouraged by the lack of statistical evidence supporting the program's effectiveness in reducing chronic health problems, medications, morbidity rate, or utilization of social and health services. It is felt that our evaluation period was too brief to capture changes in these areas but that the results of our research are strong enough to warrant further investigation of these long run effects of health promotion programs with older adults. If WWP participants continue to practice the healthy lifestyle habits they have acquired through the program, there is every reason to expect that their morbidity rates, service utilization behavior, and chronic health problems will be significantly reduced. The implications of this are profound

given the growth in size of our elderly population, the increase in chronic health problems with age, and the enormous cost of treating these problems.

REFERENCES

Bergner, M., Bobbitt, R.A., Carter, W.B., & Gilson, B.S. The Sickness Impact Profile: Development and final revision of a health status measure. Medical Care, 1981, 19, 787-805.

Brook, R.H., Ware, J.E., Davies-Avery, A., Stewart, A.L., Donald, C.A., Rogers, W.H., Williams, K.N., & Johnston, S.A. Overview of adult health status measures fielded in Rand's health insurance study. Medical Care Supplement, 1979, 17, 1-131.

Campbell, D.T., & Stanley, J.C. Experimental and quasi-experimental designs for research on teaching. In N.L. Gage (ed.), Handbook of research on teaching. Chicago: Rand McNally & Co., 1963, 203-204.

Elinson, J. Effectiveness of social action programs in health and welfare. In Assessing the effectiveness of child health services, Report of the fifty-sixth Ross Conference on Pediatric Research. Columbus, OH: Ross Laboratories, 1967.

Weiss, C.H. Evaluating action programs: Readings in social action and education. Boston: Allyn and Bacon, Inc., 1972. (a)

Weiss, C.H. Evaluation research: Methods of assessing program effectiveness. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1972. (b)

Democratic Team Management

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Kelley Reid
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Rethinking the nature of the workplace is the key concept in our development of a team approach. Traditionally, the workplace is defined almost exclusively by managers and/or owners, with the managers higher up in the hierarchy having more authority, and often more responsibility. Positions of increasing authority typically are accompanied by higher pay and greater decision making control. The desirability of these positions within the hierarchy adds to the already strong societal emphasis on competition, since most people want to get to the "top" where the greatest professional and personal rewards are available. In this climate of competition, one primary norm is personal aggrandizement. Even the classic corporate team player strives for the position of "star player" on the team.

Reconceptualizing the workplace is nothing less radical than reformulating basic premises about the definition, control and ownership of both the processes and products of work. It means transforming the approach to workplace production from the competitive "I" to a collective "We." Our experience suggests this transformation is never completed but ongoing, as workers and workplace demands change over time. The process of transformation is as important as any transformed product, and the implications extend beyond the individual work group or workplace to the nature of society in general.

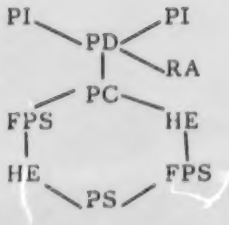
There are many forms of participatory management, each an unfolding process for representing increasing worker involvement in the workplace. Zwerdling, in Democracy at Work, (1980) describes participatory management as a continuum which could include humanization of work, labor-management quality of work-life committees, worker-owned companies, worker self-management, and worker ownership and self-management combined. Each form of management consists of specific elements which bring an organization closer to worker direction in the production process, the nature of the product, and its ultimate distribution.

In this chapter we describe basic elements of our experience in increasing worker control and ownership over the implementation of the Project goals and objectives. Through our analysis of the team process, structure, and relationships with the staff or the sponsoring organizations, we hope to make it easier for others to develop and implement elements of participatory management in their own work settings. This analysis of democratic management is divided into five areas: Evolution, Process, Structure, Organizational Relationships, and Team Products.

THE EVOLUTION OF THE TEAM

The Wallingford Wellness Project (WWP) began as a research and demonstration project, funded by the Administration on Aging, at the University of Washington, School of Social Work in the Spring of 1979. After six months of staff recruitment and program planning, the Project personnel consisted of two Principal Investigators, Project Director, Project Coordinator, Project Secretary, Physician's Assistant/Health Educator, Social Worker/Health Educator, Research Assistant and two second year MSW field practicum students. At that time, the operating organizational structure remained largely unspecified except that the Project Director was responsible to the Principal Investigators, and a Steering Committee and had authority and responsibility for the staff which was typically initiated through the Project Coordinator. The atmosphere was informal and cooperative, but the decision making structure was hierarchial. The organizational structure is described by Figure 1.

FIGURE 1



Key

FPS = Field Practicum Student
HE = Health Educator
PC = Project Coordinator
PD = Project Director
PI = Principal Investigator
PS = Project Secretary
RA = Research Assistant

Early in October of 1979, the Project Coordinator met with the Project Director and each staff member to identify her or his preferences for the Project's organizational structure. Based on this information, he presented options to the staff in a meeting which included everyone except the Principal Investigators.

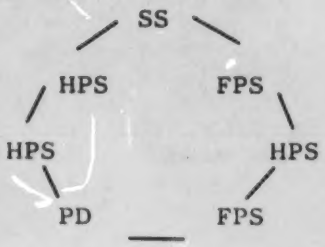
The staff agreed to develop the organizational style and structure in an evolving fashion. The process of creative team decision making thus began with a decision to work together collectively. What evolved was an increasingly participatory management structure with ultimate responsibility carried by the Project Director and the PIs, but with increasing staff team authority over all decisions related to program delivery such as participant recruitment, program content and processes, public relations, and management of the program budget. Final authority and responsibility for Project decisions such as personnel, overall budget and research activities remained with the Project Director and the PIs, but as the staff team became more knowledgeable and influential in these areas also, the PIs became less directly involved.

What occurred was a gradual shifting of power and influence toward those closest to delivery of the product. This phenomenon was not as much the result of formal structural reform as it was a result of the ongoing process of reconceptualizing the workplace towards group cooperation and away from interpersonal competition. Figure 2 illustrates the organizational chart as it developed over time. The three decision areas of program and internal administrative decisions, external administrative and research decisions, and the coordination of self-selected tasks were interrelated and operated simultaneously. A description of the process of self-selecting tasks is located in the next section.

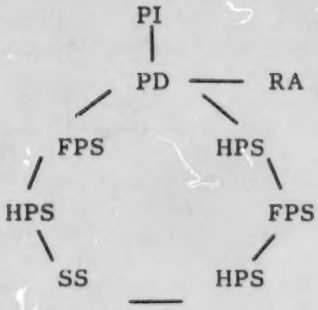
The major differences between the staffing patterns noted in Figures 1 and 2 are the changes in titles from Health Educator and Project Coordinator to Health Promotion Specialist; the expansion of the Project Secretary position to include budget and personnel management thereby becoming Support Services Manager; the fluctuating number of Field Practicum Students from 2 to 5 to 3; the transition to only one PI due to the death of Art Farber; and the expansion of the Research Assistant into a Research Associate position to coordinate the research efforts.

FIGURE 2

Program and Internal Administrative Decisions



External Administrative Decisions and Research Program Decisions



Team Coordination of Self Selected Tasks

Key

ATC = Assistant Task Coordinator

FPS = Field Practicum Student

HPS = Health Promotion Specialist

PD = Project Director

PI = Principal Investigator

RA = Research Associate

S = Staff

SS = Support Services

TC = Task Coordinator

TEAM PROCESS

The characteristics and abilities of the individuals involved were critical to the development of our participatory management process. There was a wide range of the necessary skills available including the ability and desire to work as a group, a strongly shared commitment to the purpose of the Project, an ability to take personal responsibility for initiating and completing team-determined tasks as well as deriving satisfaction from the shared process. It was important to clarify the individual values and abilities of group members since they would affect working relationships and outcomes. If value orientations are too disparate, the participatory management process may lead to frustrate the efforts of the entire work group.

One of our earliest decisions was to approach problems and tasks by using a consensus decision making model. Individuals could block consensus or disagree without blocking consensus. Important decisions to commit the Project to a work task, develop long range planning, or implement plans such as participant recruitment were agreed on by the entire team. However, routine decisions such as day to day budget management on the selection of training materials for a particular session involved individual discretion. We attempted at one point to formalize the consensual process by verbally affirming each decision with each group member, but this cumbersome process gave way to a more informal system that included working through disagreements until they were resolved, touching base with quieter group members at times, and being assertive in presenting one's views. Decision making in a more formal round-robin fashion generally occurred when there had been a good deal of debate about a controversial issue.

When a staff member volunteered to coordinate a particular event (e.g., arrangements for graduation) the staff granted the authority to develop and pursue this task and to make any necessary decisions within the parameters of that task, as reflected in the Figure 2 diagram on the Coordination of Self Selected Tasks. Based upon individual style, the task coordinator sought input from the staff at an early stage, developed a plan, and then came back to the team at a later stage for input or for assistance. For example, one team member (task coordinator) volunteered to draw up a participant recruitment plan, presented it to the team where it was modified by consensus; two team members (task and assistant task coordinator) agreed to take responsibility for implementation; and other staff members took on subtasks as

the plan unfolded. Staff members selected tasks based on their skill level, interest, and desire to develop new skills.

Seeking and achieving team consensus on major issues and delegating decisions to small groups or individuals on more routine work was a major factor in the development of an increasingly efficient and effective work group. At least six other important factors contributed to this process.

First, we shared a common understanding and commitment to the tasks before us. To a large extent, this derived from the fact that annual plans and specific projects were developed and agreed on collectively.

Secondly, over time staff developed an emotional attachment to each other, the team process, the Project, and participants. As we learned to trust each other, we began to think and act more as a group.

Third, communication skills improved as we worked together and grew to understand each other, in part by sharing feelings and criticisms before they built up and blocked communication. This was encouraged and demonstrated at meetings.

The fourth factor is the norm of redistributing work to help alleviate excessive workload stress. This evolved, in part, because individuals learned more effective assertiveness, and time and stress management skills. Team members learned to ask for help, to check in with other members who gave signs of overload, to prioritize tasks and to say "no" to offers and requests beyond the scope or energy of the Project. During earlier stages of the Project, we often succumbed to trying to do everything, for everyone, and all at once! This was due in part to enthusiasm, workaholism, trying to please everyone, trying to prove our worth, and individual agendas for career or self-worth enhancement. Incorporation of stress management techniques meant practicing what we were preaching. We asked for and received shoulder and neck massages, took noon-hour walks or runs, and took stretch or meditation breaks as needed. In the last two years of the Project, staff also made use of the reduced hours imposed by budgeting constraints and worked a 32 or 26 hour week.

Fifth, weekly staff meetings provided a predictable and established setting for ongoing exchange of information. From the very first staff meeting, we rotated weekly facilitator and notetaker roles. (The Project Director chose not

to participate in these tasks which contributed to the ongoing lack of clarity about her role as "team" member.) These rotated roles were meaningful because they immediately established an atmosphere of equitably sharing tasks that were self-selected, tasks that needed to be done in order to function, and tasks that are traditionally seen as powerful (facilitator) and therefore usually desirable, and mundane (notetaker) and therefore generally less desirable. The staff meeting served as a focal point for developing our management style and clarifying our understanding of the highly participatory nature of our program. With few visible and accessible team management models to guide us, we came to rely on our staff meetings as the arena for defining the participatory process.

Consequently, a good deal of energy went into maintaining the integrity of the staff meeting as the legitimate decision-making body. An agenda was posted for the week where any staff member could list her/his concern, the time it would take, and her/his initials. The week's facilitator would convene the meeting, read agenda items, and facilitate the flow of work. The person who placed the item on the agenda would speak to the issue at hand, and the team would discuss it and make any necessary decisions. When the decision was made, it was recorded in the notes and became the responsibility of the entire team to be sure that someone volunteered to carry out the decision. This responsibility for follow-through was critical. If a decision is not implemented, the time that went into making it is wasted, and morale and trust can break down. This could then undermine the team process. Commitment to attending staff meetings is another critical issue. At one point, for a period of about two months the Project Director attended irregularly, which resulted in feelings of alienation and a breakdown in trust as well as limited information exchange. Discussing this with her resulted in her renewed commitment to participate in staff meetings and to reestablish the communication levels which were essential to effective team operation.

Finally, the size of the staff team helped us to work in a participatory way. The team has ranged in size from four to ten members, some working part-time and some full-time. With each additional person, the time and energy needed to maintain clear communication increases. In general, smaller participatory work groups are easier to establish and more efficient. This does not preclude team management in large bureaucracies if the entire organizational effort is divided into interdependent democratic work groups.

One of the key issues that emerged in developing the team process was a recognition that staff meetings could not provide the sole forum for all decision making. For example, when there were decisions that needed to be worked out by the team but were too complex or lengthy to be dealt with during a staff meeting, a retreat was scheduled. These retreats constituted one of the six basic types of meetings the staff found useful: (1) planning, staff orientation, and team building retreats, (2) "process" meetings, (3) program support meetings, (4) inservice training meetings, (5) staff evaluation meetings, and (6) general staff meetings.

Retreats ranged from one-half to two days in length, were informal in atmosphere, and were used for purposes such as long-range planning, orientation of new staff, and team building. A related meeting was the "process" meeting, held when one or more group members identified a need for a discussion of feelings about work or interpersonal issues and the rest of the team agreed to listen and to problem solve regarding these concerns. These meetings often played a part in redistribution of individual workloads. The third type of meeting was a support meeting which focused on classroom program delivery issues and was held by those team members facilitating classes. These were held "on demand," and proved helpful in problem solving and sharing information about class content, process, procedures, and participants. The fourth type of meeting dealt with such inservice needs of staff as groupwork skills, time management, and giving feedback. The fifth type of meeting was the six-month staff evaluation designed to enhance performance and work relationships based on career development rather than productivity criteria. General staff meetings were the sixth type of meeting and included personal and process components related to the business of the day. These meetings began with a round robin procedure for sharing feelings called "check in" which gave people an opportunity to establish contact with one another, to identify the amount of energy they had available for meeting issues, and to make the transition from other tasks and concerns to the business of the group.

While staff, at times, felt the team was overburdened by meetings and sometimes lost patience with the number and length of team meetings, the variety of meetings related to decision making and information sharing helped to reduce the need for conventional "old boy networking" where agreements and transactions are made informally, competitively, and not necessarily most productively (Freeman, 1973). A variety of consensus oriented meetings served an important function in maintaining egalitarian decision making. In addition, as the

team process developed and increased in efficiency and effectiveness, the number and length of meetings diminished.

One major personal benefit of the team process was the opportunity it provided for flexible, open-ended job roles based on individual interests, skill levels, and desire for growth in given areas. There was definitely support and encouragement for developing new job skills. However, there were also barriers and problems with this possibility.

The skills which staff possessed coming to the Project predisposed the team to delegate certain tasks to specific people. Two examples, are the Support Services Manager's ability to type and the Coordinator's ability to plan. Also, certain jobs, like report preparation, budget management, typing and filing were seen by several team members as less desirable or possessing less status. At first, these jobs tended to remain with those who already had the greatest skills in these areas. During the last year of the Project as work assignments needed to be reorganized due to staff changes, there was more sharing of administrative tasks. It must be noted that tying individuals with special expertise to specific job roles often enhances effective and efficient management and production, particularly in the short run. However, the long-term value derived from the flexibility, versatility, and personal growth which results from some rotation of job roles can be significant to the organization. In addition to the personal benefits, role rotation and/or task sharing contributes to awareness of overall organizational efforts, investment in the quality of the work product, ability to "fill in" the gaps caused by inevitable personal or organizational demands such as individual emergencies or budgetary reallocations, and perhaps most importantly, a more universal awareness of the significance of each role or task to the creation of the ultimate work product.

A related dilemma was the desire of staff, especially practicum students. to develop skills which were not always considered the highest priorities for effective operation of the Project. This problem was partially compensated for by the additional energy which new staff bring with them and the creative energy which accompanies new learning. To address this, learning contracts were developed with practicum students at the beginning of their placement which spelled out team needs as clearly as possible, and simultaneously identified student learning goals. Thus, the synthesis of organizational needs and individual goals was mediated by the team as a whole.

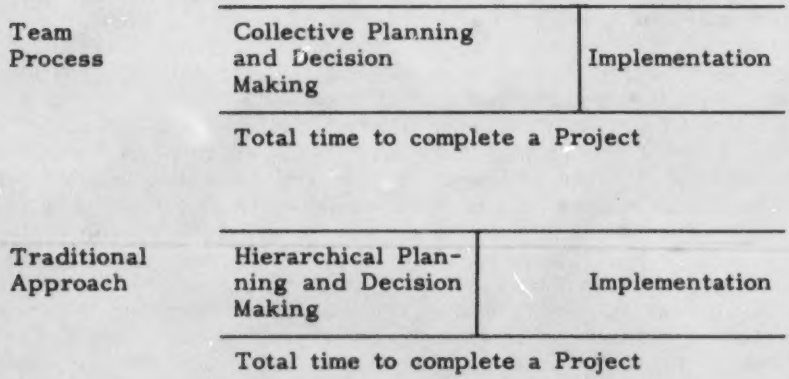
One of the greatest strengths of team management as identified by students and all staff members is the opportunity to learn, develop skills, and grow in personally rewarding ways. The learning potential of this model is immense if people are willing to expand, work, and take risks. Increased competence and confidence are the result. Jeam Carter, a graduate student who joined the Project in its third and final year, made these observations:

> "Two things stand out for me about the Project as a learning experience, both having to do with the team and the way it works. First, is the truly remarkable degree of support which the team generates for itself. The impact of this strong, unqualified support cannot be overemphasized; for the practicum student it means freedom and safety to learn as much as possible as quickly as possible.
>
> Second is the clarity and efficiency with which the team works. I was particularly impressed by the fact that all the energy in staff meetings and in day-to-day operations appears to go into getting the job done. This degree of focus on the task is unique in my work experience of some 15 years. Matters of alliance, power, competition, oppression and status all of which consume so much energy in the "normal" work situation were absent. In addition, the team had learned to communicate with each other so effectively and economically that time was used very well. To observe and be a part of such an efficient, lean operation was enormously valuable to me."

Over the life of the Project there was an increased sharing of all job roles among staff based on both personal and team needs as well as a process of negotiation and growth. We continued to monitor the efficiency and effectiveness of the team management process. While we were committed to a participatory approach, we were equally committed to the delivery of a worthwhile product.

Because of our emphasis on the whole, on collective decision making, on flexible job roles and on "the intimacy that grows out of collaboration," we found, as did Ouchi (1981) that once we had completed our slow consensus building process, the decisions were carried out creatively and efficiently. This is conceptualized and compared with a more traditional approach to planning and decision making in Figure 3.

FIGURE 3



The critical aspects of collaboration are that the people who implement the plans also share in the creation of the plans, so they have as strong a commitment to process as to task, and that production objectives are built on shared values. The result is not only greater organizational efficiency but ultimately a better outcome. It took a good deal of effort and time to develop our management process to the point where it became most efficient. In terms of both probable long range outcomes and the quality of our immediate product, this investment of time and energy has proven worthwhile.

TEAM STRUCTURE

The purpose of the team structure was to create a working climate where the "production process" could best occur. The process and the structure evolved together in a mutually supportive way. An important concept in a participatory structure is that the structure serves to enhance the process, not vice versa as in most traditional approaches. This requires flexibility, clear communication, and trust.

One of the first structural innovations to be implemented was equal pay for all members of the ongoing team except the Project Director. Referring back to Figure 1, this applied to the Project Coordinator, the two Health Educators, and the Project Secretary. At various times, people in these positions have worked varying numbers of hours in a given pay period, but the hourly wage was the same for each of the

four positions. The PIs, Project Director, work study Field Practicum Students and Research Associate, who received salaries from the University of Washington, were paid differently, according to a traditional hierarchical model.

Equalization of pay was an action which helped create a more participatory management process. However, for some staff it was not as critical an element as might be expected. For instance, the Project Secretary who was with us for most of the first year of the Project received an equal salary and yet was less a part of the team effort than the Field Practicum students at that time. One reason for this seemed to be that he shared less of the common value base which influenced him to play a less involved role in terms of decision making and taking on responsibilities and tasks outside of his area of greatest experience. Also, the position of secretary traditionally has less functional flexibility in that it is commonly limited to clerical and administrative support work. Also, his previous career experiences in secretarial positions (about 15 years) may have influenced his interest and ability in playing a new and broader role.

It is interesting to note that there was minimal resentment from Field Practicum Students toward staff or staff toward Project Director or Research Associate about differences in pay. This may have been because it was clear we were all working together and saw each other's efforts in accomplishing what we set out to do. Also, many students accept low or no pay as the reality of participation as a student in training. However, the wage inequities inherent in the larger university system were apparent to the staff and at times these inequities were resented.

Another important structural aspect was the hiring procedure. Original staff were hired by the PIs and the Project Director with the help of the Senior Center Director and the Project Coordinator. As new positions (eight Field Practicum Students and two ongoing staff) were filled, however, the entire team worked with the Project Director in hiring. In each case the Project Director followed the recommendation of the team. Each position had a job description developed by the person in that position. This was used to derive criteria for the hiring of each new person. One important criteria for selection was that any new team member share our common value about participatory work.

Staff evaluations were conducted every six months to assist individuals in improving personal work performance and for the team as a whole to improve its functioning. The

evaluations were based on performance and working relationships vis-a-vis job descriptions. At these evaluation sessions each staff member was allotted 30 minutes in which to share with the rest of the staff her/his own assessment of strengths, identify skills yet to be developed, and roles she/he would like to assume or pass on to others. Following this self-assessment, each staff member would ask for feedback from the rest of the team, and changes in job descriptions would be developed if needed. After individual evaluations, we discussed the work of the team as a whole--where we were doing well, how we could improve, and how effectively and efficiently we were meeting objectives and suggested timelines. Following these meetings, each individual would revise her/his job description to most accurately reflect what would be needed over the next six months to meet the Project objectives, taking into consideration the individual objectives as well. Thus, these evaluation sessions assured individual accountability to the team and self as well as assuring team responsiveness to the individual.

The sessions involved risking, self-disclosure, and confrontation, and were emotionally difficult at times. However, the process encouraged developmental rather than judgmental feedback, and, most often, staff found them supportive and growth-enhancing. They increased trust and fostered a sense of team cohesion. The procedure of revising the job description resulted in change from very individualized job descriptions to a more general or collective job description (see Appendices N, O, and P). This more collective job description illustrates the evolution of the team process, the result of sharing job roles and decision making over time. However, the Support Services Manager's position has remained separate from that of the Health Promotion Specialists.

The extent to which decision making power is skewed by the team's ability or inability to share roles and tasks and the extent to which more static job roles limit the professional growth of the individual are concerns that have been expressed and not fully resolved. Other important considerations that critically affected our decision making were proper mechanisms for information sharing, the effect of traditional role expectations including sex roles in the politics of talking in female-male groups (Steinem, 1981 and Josefowitz, 1980), access to resources (especially for those less skilled in any given area), and the availability of staff development opportunities in areas relevant to individual staff growth.

Some of the innovative aspects of our team structure described in this section are contained in the Project's Operations Manual in Organizational Process and Structure, (1980). This document was a supplement to Senior Services and Center's (SSC) personnel policies manual and describes WWP personnel policies which differ from those of SSC. This separate manual was created to enhance the position of the staff team as responsible to itself and helped to strengthen the autonomy of the team.

In closing this section, it is interesting to note that the Operations Manual and many of the other formalized structures discussed here are like anchors of a ship. In rough, uncertain and unknown seas it is good to feel their stabilizing influence or to at least know they exist. This is especially true at the beginning of a voyage. However, before setting out to sea, it is necessary to raise the anchor, leave the harbor, and put one's trust in the ship's ongoing process. The anchor is always there, and can be used when needed, but it is the process of sailing that makes progress.

RELATIONSHIPS WITH SPONSORING ORGANIZATIONS

How was it that our team process and structure were allowed to operate and thrive within two bureaucratic and hierarchical organizations? Part of the answer to this question is that we were successful in accomplishing specific Project objectives. We did what we said we would, and from the beginning we operated at least as effectively as other organizations doing short-term projects. There was little reason, therefore, for concern or intervention into our internal affairs by the sponsoring organizations. Several other factors influenced our success within these two hierarchies.

One reason was a continuing dialogue with the people involved in these external groups. This was one of the main aspects of the role of the Director as liaison person with the School of Social Work (SSW). It was also the role of both the Project Director and Project Coordinator as members of the Steering Committee, an advisory committee established before Project operations began. Other staff members met regularly with the Director of the Wallingford Senior Center and provided a liaison with Senior Services and Centers (SSC) which enhanced smooth administrative functioning under the Project's subcontract with SSC. All staff members were aware of the importance of the relationship to these sponsoring organizations and, thus, in varying degrees played liaison roles.

These ongoing relationships between the WWP staff, SSC and SSW contributed significantly to the flexibility and creativity of Project operations. Each liaison role called upon different experience and skills of team members. For example, the Project Director's liaison activities with SSW, Administration on Aging, and SSC personnel were enhanced by her administrative skills and experiences in both educational and community-based service delivery settings as well as previous involvement in federal grant projects. Some of the skills and attitudes which her liaison activities called for, include:

1. Commitment
2. Tolerance for complex organizational interfacing, e.g., three unrelated organizations, AOA, SSW, and SSC were directly involved in different aspects of project operation, each organization had distinct and not necessarily compatible goals and objectives with regard to the Project and each organization had distinct organizational structure and procedures with which to deal.
3. Communication skills.
4. Flexibility, patience and perseverance.
5. Organizational assessment skills, e.g., knowing when to utilize a particular strategy and when to "lay low."
6. Familiarity with service delivery and research perspectives.
7. Experience with management, budget, and evaluation.
8. Experience in a liaison-boundary role between hierarchical and non-traditional organizational structures.

The combination of skills and experience enabled her to relate effectively to many different people involved directly or indirectly in project operation.

Succinctly, the ability to "speak the language" of key people with different organizational perspectives and values was critical to the Director's successful liaison efforts. These activities contributed directly to the creation of a "buffer zone" where the team could operate with minimum pressure from outside the work group.

Other team members played similar roles, consciously attempting to meet the needs of SSW and SSC for information,

input in planning, and a sense of involvement in the Project. These needs were met to varying degrees through routine team procedures. For example, copies of staff meeting minutes were provided to those persons from the SSW who were interested in Project activities.

The Project Director met individually with the Dean, other administrative personnel of the SSW, the Principal Investigators, and the Director of the Center for Social Welfare Research to share information and problem-solve. In retrospect, these meetings and the attendant working relationships could have been more effective had the meetings taken place more regularly rather than "on demand," as a need arose, or when time permitted.

Other important factors that increased the feasibility of our management style within the traditional hierarchy of the SSW include:

- The principle of academic freedom. The University does not tell a Principal Investigator how to run her/his demonstration research project.
- The nature of the following tasks allowed for more staff autonomy: community organizing, planning, recruitment, public relations, program delivery, curriculum development, development and dissemination of informational materials, research, administration, and volunteer training and coordination. Close control of all the diverse elements of a community-based research project is often counterproductive, if not impossible.
- The need for and advantage of flexibility in decision making at the service delivery level was negotiated by the team and supported by the PIs and the Executive Director of SSC.
- Support from some people in the hierarchy. A 'wait and see' attitude from others.
- The off-campus location of the Project enhanced development and enabled the staff to develop a separate identity as an autonomous unit requiring minimal day-to-day physical supervision.

As the program began to demonstrate success in meeting its objectives and the startup pressures lessened, there was reduced involvement of the PIs. This affected the role of the Project Coordinator in a way that helped to increase the participatory nature of the team process. This allowed him to become less involved in liaison work between the team and the

Director. He was also more willing to share administrative duties, and staff were more willing to assume these responsibilities. Thus the tasks of report writing, long-range planning, budget management and informational link to Project Director became shared with the rest of the team.

One reason the Project Coordinator held on to his roles (and the power they possessed) for the first year is because he was perceived by the Project Director as the person on the staff team with ultimate responsibility. Though by definition the entire team was vested with the responsibility and authority to determine the team's actions, in practice the Project Coordinator was held responsible. This led him to "hedge his bets" as it were by keeping as many roles as possible. We learned that any role with unequal access to information can result in skewing the decision making power and thereby undermine a consensual model. Also, one person who is consistently responsible to an outside authority for the actions of a group, may "fight" to maintain power to protect her/his vulnerable position of being responsible but without official authority. As administrative responsibilities were established and more equalized access to information was established, especially with the Project Director, a major shift in equalizing team power was accomplished.

In concluding this section, one point should remain clear. There is no guarantee of permanent ownership and control over the workplace by workers who use a participatory management style within a hierarchy. The trappings of final authority remain outside the team's control. However, we have never been without power as a team, and have, in fact, gotten most of what we wanted in order to perform our job. The parameters of power can be perceived as both limited and broad. By understanding these perceptions, the range of options for action becomes clearer. We were able to achieve greater autonomy within these hierarchies, and hence strength for our position by accurately assessing the organizational value base and mission, the management structure and operation, the key links and actors, and the best points of intervention to act or lobby for what we wanted. By trusting in our own process we found strength in the job we were doing and gained confidence from the people with whom we were privileged to work.

The connections made with external structures have been kept viable and open over the long run. This is essential. We did, however, go through a period of "adversarial mindset" with outside hierarchies, which could have resulted

in closing necessary channels for information and communication. One result of this mindset was that it built group cohesion to a certain degree. Another result was that it drained otherwise productive creative energy. There is a danger of becoming ingrown with an "inhouse" or closed operation where defenses are high and outside input becomes limited. Flow of incoming perspectives and information is critical to an evolving, flexible operation. An example of being open to new perspectives and energy that proved immensely beneficial and was critical to the successful operation of the Project, was the placement of practicum students from the School of Social Work with the WWP.

TEAM PRODUCTS

The team process and structure affected what we produced as well as how we produced it. A process orientation allowed for development and collaboration on new ideas in a less structured way, thus enhancing creativity. This orientation applied to classwork with participants where our participatory approach to management carried over into the development of a participatory learning model. It also applied to the development and revision of classroom materials, reports, and other information for dissemination. Our ability to ask for and use developmental feedback from each other, the participants, and external sources of information helped us create an educationally richer program.

One of the most intangible but, nevertheless, visible products that resulted from our experience is the enthusiasm that was generated and attitudes that developed toward participatory management. This is a transferable product which, as we all move on to other work settings, will hopefully facilitate changes in those settings in the direction of cooperative workgroups, open information sharing, equal access to resources, greater worker participation, equal decision making power, and ongoing opportunities to learn and develop skills, especially those skills necessary to keeping this process viable.

A core of Wellness Advocates will continue to carry on the banner of wellness as their mission statement attests: "to reinforce for ourselves and to share with others the concepts of wellness and to promote application of these concepts for people of all ages." In training people to teach health promotion, we spent time teaching interpersonal communication and group work skills. These skills are important not only because they enhance a participatory learning style, but also

because they increase peoples' abilities to live and work positively with others in general. This core of advocates represents a translation into action of the basic belief of empowerment, enhancing the ability of others to act, to perform effectively on behalf of themselves and/or their community (Josefowitz, 1980). Hopefully this "product" will spread like a mustard seed.

Another product of the WWP is the research. These findings suggest the positive potential of participatory approaches. The staff team assisted in the research process by doing some of the interviews, handling the collection of all other surveys, coding, and helping with other related mundane tasks. The main responsibility for research design and analysis has been with the Project Director and the Research Associate. The team provided the interventions, i.e., the independent variables. The participatory learning approach and the participatory management style of the Project are complementry and reinforce each other. Together they constitute the core of the demonstration program.

CONCLUSION

We have described the evolution of the WWP team process and structure. We have also indicated how the team interacted with other key organization and how the team process affected the product. We hope some of what we have described here can be applied elsewhere by other work groups interested in experimenting with democratic management.

We believe that we had some success with structural change. However, more importantly, we have succeeded in evolving a process that works, one that allows the structure to evolve. This is illustrated by the fact that we did not re-write our job descriptions until we had been working for six months. Then we knew our jobs and could more accurately describe them.

It is important to recognize that long range ideals are achieved slowly. We each need to look for ways to apply whatever elements of participatory management we can in our work environment. These ideals are met through the day by day struggle in a real world. And there is always a next step. To adopt a purist or an "all or none" approach to participatory management only makes this reality less accessible to the majority of working people, many leading lives of quiet desperation.

Finally, it would be a mistake to end this chapter without at least attempting to convey some of the depth of personal transformation this team process has required. It has never been easy. We have rarely proceeded without making mistakes. Many times we have felt overwhelmed with the ambiguity, the problems, and the upheaval. Many times we longed for an easier path, to follow a linear progression of thought, or for a "boss" or an "expert" to tell us what to do. However, we found over and over that our real strength, our real creativity, our most effective and efficient productivity were attained through the process of our work and struggle together. When we trusted this process, and were able to accept the upheaval and the ambiguity, we evolved concrete plans and realistic actions that led to success.

So, if any of the descriptions in this chapter seem pat or simple, they are not. There is much complexity and emotion which could not be put into words. In some ways, it is the actual experience of that complexity and emotion which is at the core of a team management process, an experience each of us must decide to risk for her or himself.

REFERENCES

Freeman, J. Tyranny of structurelessness. In A. Koedt, E. Levine and A. Rapone (eds.) Radical feminism, New York, NY: Quadrangle, 1973.

Josefowitz, N. Paths to power. Reading, MA: Addison-Wesley, 1980.

Ouchi, W. Theory Z: How American business can meet the Japanese challenge. Reading, MA: Addison-Wesley, 1981.

Steinem, G. The politics of talking in groups, MS, May, 1981.

Wallingford Wellness Project Staff. Organizational process and structure. Seattle, WA: Center for Social Welfare Research, School of Social Work, University of Washington, June, 1980.

Zwerdling, D. Democracy at work. A guide to workplace ownership, participation and self-management experiments in the United States and Europe. Association for Self-Management, c/o 1414 Spring Road, N.W., Washington, D.C. 20010, 1978.

Epilogue: Visions for a Healthy Future

Sue Bailey Stam
Wallingford Wellness Project Graduates

To be truly healthy, we need hope and visions for the future. It seems fitting to conclude this monograph with a "visionary collage" of aspirations, dreams and hopes for a future of personal and societal wellbeing. The paragraphs in this collage were written by graduates of the Project, and it is our collective hope that this enthusiasm and message of wellness will influence future planning, program design, resource allocation and public policy decision making, as well as choices of personal healthstyles.

We begin with an emphasis on wellbeing and the belief that we can take charge of our lives. . .

> Being as one with the world is fundamental to existence. The Wallingford Wellness Project preaches, practices and puts into perspective physical, emotional and environmental wellbeing. Most importantly, the Wallingford Wellness Project stresses we have control of our own choices concerning our physical, emotional, and environmental wellbeing.
>
> A community that promotes wellness among its citizens is a community well worth striving for. The most important thing I have learned in the Wallingford Wellness Project is that I have responsibility for my own wellbeing. Will the research done in the program show that the subjects taught and acted upon have improved the lives of seniors? If so, how do we reach, motivate, and teach seniors that emotional, physical, nutritional and environmental wellbeing are amongst the choices people can make for themselves.
>
> Ruth Neham
> Age 66
> Spring '81 Graduate

Making healthy and satisfying lifestyle changes clearly demonstrate "being in charge". . .

Since graduating from the Wallingford Wellness Project, I have become more aware of my lifestyle in the following ways: (1) I pay more attention to what I eat, the amount, and the types of basic healthy food which helps me gradually decrease my weight and gives me a feeling of wellbeing. (2) I am less pressured to do things I don't want to do. It's getting easier to say NO, thereby less stress. (3) For fun, I try doing new things in moderation and I'm surprised by how much I like the new perspective. (4) Holding on to my incentives and creativity, I find self-satisfaction from taking more interest in people and being helpful. (5) When boredom tries sneaking in, I escape it by immediately thinking of something to do.

Thanks to the Wellness Project and an old friend's philosophy, "They can't bury a moving body." I feel great.

Lucille Duchowski
Age 79
Fall '80 Graduate

The Project not only teaches about recycling, it "recycles" our heritage. . .

One searches for alternatives to the insecurity and chaotic character of life today. We long for some kind of foundation, we want to find rock bottom. The great value in the Wallingford Wellness program is that it offers us these answers. We are brought back to fundamentals - we can hear echoes of Walt Whitman and Thoreau in the Wallingford Wellness approach to ecological values. The Project helps us see that there is the great America we have lost. This is the road to a truer existence. Let us share, says Wallingford Wellness, let us celebrate our wonderful heritage. Johnny Appleseed, hello! Paul Bunyan, hello!

Jack Neham
Age 68
Spring '81 Graduate

Wellness is a key to staying independent as we age. . .

> Wellness is a concept all should attain. As a person realizes one's body is the one and only body each will ever have - learning how to keep it shipshape, repairing imperfections, is necessarily a big, big part of living and making happier days in a peaceful world.
>
> My vision of the future brings hope of older folks being more able to do necessary things because they have been taught the fundamentals of healthy living within the environment, and youths no longer waste the good thing given them.
>
> Viva Wellness!!
>
> Pearl Sacks
> Age 81
> Spring '81 Graduate
> Support Services Volunteer

As we grow older, we all acquire valuable life experiences. Sharing these experiences enriches others and provides a useful resource for our community. We also like to continue contributing, to feel useful and valued by others. . .

> Primary concern for all of us is to contribute not only of ourselves but to our friends and fellow man. The Wellness Project underscores this criteria. The association with people that have experienced not only the happiness of life but also its trials and hardships is rewarding to all of us. We grow by association.
>
> A fitting creed for our people is --
>
> Four things a person must learn to do
>
> To Think without confusing clearly,
> To Act with honest motives surely,
> To Love your fellow men sincerely,
> To Trust in God and heaven securely.
>
> Don Elsom
> Age 71
> Winter '81 Graduate

Learning is ageless, and learning together and acknowledging our common concerns is a powerful experience. . .

> The benefits are countless when you are in a group of people who are so knowledgeable in many diverse areas. As I stated before, I have not yet achieved all my goals in lifestyle change, but now I can see where the changes need to be made and how I can accomplish them. For me, it's almost like starting my learning years all over again, as I have truly been in a "rut." I doubt I would have gotten into an exercise program on my own if it hadn't been for leadership and group action. It's also been very important to learn the right ways in lifting, reaching, carrying, etc.
>
> All the consumer information is of much value, especially for those of us on limited incomes. The assertiveness and constructive criticism sessions were very helpful. And I think it's been so important to learn that there are many of us with concerns of our environment and our hopes for a peaceful world where in brotherhood no one need know the pains of hunger and fear.
>
> Anonymous
> Spring '81 Graduate

Further testimony to the fact that learning is ageless. . .

> At my age it is hard to "learn new tricks." To be educated in the wellness ideas is both worthwhile and surprising. The new diet and exercises changed my body, I lost 6 pounds when I started the wellness course but gained it back (for years I have weighed 133 pounds). I am bent and brocky, but I feel I am straightening out - I tell my age at 28 not 82 and feel great.
>
> Victor Lindahl
> Age 82
> Spring '81 Graduate
> Wellness Support Group

The "ripple effect" of the Project beyond our targeted goals includes influencing family and friends. . .

> When I read about the Wellness program being offered at Wallingford Senior Center and registered for it, I really didn't know what to expect. During

my twenty-one week attendance at classes, the myriad of things I learned about stress management, nutrition, and environmental awareness was unending. I thought that I had been pretty well aware of a "right kind of life," but what I learned in my classes made me so aware of changes I could make in my way of life that I could envision not only living longer but living healthier and better for myself, and my family and friends that I have included in my new "education." In fact, my daughter-in-law, who was driving from Everett to Seattle each Wednesday to attend the University, would meet me at my office when I arrived from class, and she and some of my co-workers couldn't wait for me to review each week's subjects. These 21 weeks of learning helped all of us to be aware of a better way of life!

Lynn Pritchard
Age 66
Spring '81 Graduate
Wellness Support Group

We could not have hand-picked a more "Peckham-like" community facility to house the Project. . .

Having lived in the same house and neighborhood for over 40 years, the Good Shepherd Center has special meaning to me. Built on the brow of a hill, this sturdy grey stone building and grounds have stood as a citadel overlooking the nearby residential and business community. It has endured through many changes.

I remember its earlier purpose was that of a home and school for pre-delinquent girls. When this service was no longer appropriate at this site, there was a scramble by investors to change the entire complexion of the building and grounds. Proposals were rampant to turn this area into a shopping center, surrounded by apartments, condominiums, and other housing. I remember, too, the tremendous community effort which was made to successfully abort these plans, and how finally the way was cleared to make Good Shepherd Center into a community multi-purpose center.

To me the fact that WWP was housed at Good Shepherd Center was a plus - the intermingling of members with Senior Center members, at times only a "hello," a greeting, seeing the young children

going to Montessori School, the ballet dancers to their practice, the crafts people coming for weaving and pottery, in other words, the world in microcosm, a community of many smaller communities.

Margaret Oliver
Age 69
Fall '80
Wellness Support Group

A prediction of movement toward self-responsibility. . .

From where we stand today I see ever-widening waves of wellness reaching forward to future generations. The greatest change will be the shift of responsibility to self from dependence on medical professionals whose role will become supplementary.

Felicita Schoenfeld
Age 65
Spring '81 Graduate
Wellness Advocate

Support groups are an important vehicle for maintaining healthy changes. . .

Through the Support Group I had a chance to follow up my wellness classes and develop positive health behavior. I was able to improve my hypertension, my eating habits and sleeping habits! To incorporate wellness into everyday life, I would suggest: (1) to teach classes with graduate students; (2) develop support groups of not more than 15 people to support each other in our lifestyle changes, engage speakers, and invite any senior citizen to join in on the program; (3) introduce our Wellness Project to other Senior Citizen Centers and to coordinate our program together.

Erica Duringer
Age 74
Fall '80 Graduate
Wellness Support Group

Providing ongoing health promotion education for all ages is a vision. . .

> I envision life long community-wide emphasis on Environmental Assertiveness, Nutrition, Exercise, and Stress Management, through the public schools and on into continuing education using appropriate materials and methods for the age of the groups. The reason for thorough, structured, ongoing public education in Wellness is that everybody needs it for as long as one lives, and the latest confirmed scientific findings need to be transmitted through the teaching staff. Another reason is the need for good health in order to get the greatest enjoyment out of life, thus helping the individual to maintain her/his good-health-oriented direction as she/he learns new facts and reviews helpful methods and material learned earlier.
>
> I would hope that legislative bodies would fully fund this education, realizing its wide-ranging ramifications.
>
> Virginia Lindahl
> Age 67
> Spring '81
> Wellness Support Group

Participants are currently working with the Seattle Public Schools to help instill in our children the concepts of a wellness. . .

> The Wallingford Wellness Project has done more than increase the knowledge and self-responsibility of its participants; it has produced a group of "Wellness Advocates." As such, we are committed to work toward a level of optimum health not for ourselves but for the community as well. My personal goal is to bring "wellness" into the schools so that our children can grow up with these ideas integrated into their lifestyle. This is my vision for a healthy future.
>
> Linda Goldman-Thal
> Age 36
> Spring '81 Graduate
> Wellness Advocate
> Advisory Committee Member

As we move ahead with the Wellness Project, I plan to work with the public school superintendent

to provide wellness materials to public school teachers (especially physical education, health and nutritional personnel) and students (especially the teenagers). Wellness ideas can add energy and enthusiasm about healthy lifestyles. I'm sure I can sell the ideas to the young people as a positive approach to eliminating alcohol, drugs and smoking from their lives.

Della J. Patch
Age 84
Fall '80
Wellness Support Group
Wellness Advocate
Advisory Committee Member

The concept of synergy is a key to understanding wellness. . .

The class has introduced the way to integrate - put in proper places - those efforts I wanted to make better for myself and my family's way of living. It has helped us to survive meaningfully and practically. And it has demonstrated to us ways to achieve a more healthful daily life and prevent disease. I feel that the course helped us to realize how everything relates and cannot be isolated in discrete parts. One thing is affected by another.

Anonymous
Spring '81

Community and caring are themes that are essential to the spirit of the Project and to ongoing health promotion. . .

When I think of wellness, I think not only of a healthy body and mind but also of a spirit between people. In my experiences with the Wallingford Wellness Project, both as a participant and as a Wellness Advocate, I felt a sense of community among the people in the classes that was very heartwarming. This sense of comraderie was a factor in helping me to make and maintain many healthy changes which the project advocates.

Another concept which was emphasized was synergy -- the whole is greater than the sum of its parts. This is important as it helps us to realize how we fit into our universe and recognizes the need for us all to take responsibility for the

wellbeing of our community. As we work towards maintaining well bodies and minds, we must also work towards maintaining a healthy environment. We depend upon this earth and it is depending upon us.

Cheryl Ellsworth
Age 28
Spring '81
Wellness Advocate

Regaining my sense of self. . .

At the time that I joined the Wallingford Wellness Project, I was at a very low point in my life. I felt physically and emotionally exhausted. Becoming involved with a group of such warm and friendly people and acquiring new and healthier habits has helped me regain my enthusiasm and a sense of wellbeing. I hope to remain involved in the Project as I would like to help others make healthy changes in their lives.

Lucille Williams
Age 60
Spring '81
Wellness Advocate
Wellness Support Group

Active and involved volunteers have contributed so much to the overall enthusiasm and success of the Project. . .

For 24 weeks we attended classes on nutrition, exercise, stress management, and environment. After graduation, we formed a support group in teaching what we had learned in classes to the new classes. We were enthusiastic about doing this for we had learned to put our priorities in order, to take good care of our bodies through proper nutrition and exercise, and to develop methods to reduce stress. We enacted situations in class on how to be persuasively assertive, learned how to relax, to enjoy our natural environment, and most of all how to share our ideas with others. We volunteered to participate in nutritional discussions at Encore - a city wide program for the elderly. We also were a part of the Challenge of Change as covered in the Western Gerontological Society's 27th Annual Meeting in Seattle, April, 1981. Every graduate of the class is now actively engaged in

doing his or her part in seeing what will enable others to enjoy the same benefits we enjoy - in living a fuller and better life.

Ben and Letty Tappe
Ages 74 and 73
Fall '80
Wellness Support Group
Wellness Advocates

To realize that we do have choice and can act on our choice is essential to recognizing our own personal power. . .

Condensing 15 months of incredible, invaluable, delightful and sometimes even painful experience into a paragraph or two will not be easy! My participation in the Wallingford Wellness Project has been as a member of the second class, a co-facilitator of another class, and currently facilitator of the Wellness Advisory Subcommittee for the Wallingford Senior Center.

By exposure to a variety of issues and ideas in the four subject areas of the classes, I was challenged to accept responsibility for choosing my individual response and approach to our complex physical and social environment compatible with my own daily routine. Mental and physical wellbeing and social consciousness are very personal issues. The participatory model and supportive group atmosphere allowed for an individual, flexible response.

Susan Newcomb
Age 24
Spring '81
Wellness Advocate
Advisory Committee Member

Some visions for perpetuating wellness are already being realized. . .

The opportunity to participate in the excellent wellness classes is deeply appreciated. The staff was excellent and I feel that my physical and mental health have improved. My fervent hope is that the

classes will continue so that senior citizens and others may also benefit.

Germaine Schuster
Age 72
Spring '81
Support Services Volunteer

To extend the knowledge gained through Wellness and by having an exercise class, everyone will be healthier!

Rosalie Aschenbrenner
Age 57
Fall '80
Wellness Support Group
Wellness Advocate

Wellness classes connect with and spark people's enthusiasm. . .

The Wellness Project class was one of the most valuable I have ever taken. Not only was the knowledge imparted on nutrition, exercise, stress management, and environmental assertiveness very useful, the positive and warm ambience of the classroom was a great joy. It would be my wish that funding could be found so this class could long continue in Seattle for people of all ages.

Frances McEvers
Age 69
Winter '81

Application in the workplace. . .

Individual commitment to wellness will lead to community wellness. Company instituted wellness programs can reduce absenteeism, thus benefitting the company as well as the individual. Individuals practicing wellness throughout their working years would be better prepared for their golden years.

Chuck Knudson
Age 64
Fall '80
Wellness Support Group
Advisory/Steering
Committee Member

Wellness Advocates spread the word to their communities. . .

I am a graduate from the first series of Wellness classes, held at the Wallingford Senior Center. I am also a "Wellness Advocate," which means that I participated in a series of classes which trained us to become wellness class instructors. My home is in the Bothell community, which is about twelve miles north of Seattle. I, along with three other Wellness Advocates, are about to start our second series of classes, to be held in the multi-purpose center in our little town of Bothell. Our classes are in affiliation with the Northshore Senior Center, and we deal mostly with people 55 to 70 years of age. In our classes, we have tried to relate wellness to problems and changes that are taking place at these ages. We are finding that as our class learns more about their own feelings and needs, especially in a group situation, they are becoming more aware that these same needs and cares are those of the rest of the community, and then of the whole world.

It's interesting to note that when we tell groups about our wellness classes, and how we associate nutrition, stress management, assertiveness training, and exercise, with being physically and mentally fit, that the comments we hear are, "say, that sound like just what I need." Then, as they hear others expressing the same needs and desires as their own, they seem almost surprised, and a certain bond and relaxation begins to appear.

It's my sincere desire that these beautiful classes will soon reach to all ages, even to the infants, who will grow up with these teachings and not have so much to "unlearn," as we have.

These classes were so freely and lovingly given to me, and I find that it is impossible for me not to be passing them on, to the best of my ability, so that others lives will be blessed, even as mine has been. I know that the participants in our classes will, each in their own way, spread these

good teachings, and I can't think of anything that could bring a healthier future to my community, or to the world.

Bonnie Dewey
Age 57
Fall '80
Wellness Support Group
Wellness Advocate
Advisory Committee Member

A personal philosophy for living. . .

Wellness is both a physical condition as well as a state of mind -- and it can be quite different for different people. We each have limits and capabilities. I feel that the well person's lifestyle is difficult to maintain in our society. We need other people to encourage us to reach our goals in our efforts to become the person we want to be. I am constantly eager to enlarge my support system -- I really need others to participate in my wellness plans with me. If you want someone to exercise or share a good meal with -- I am happy to get together with you! Wellness also means caring for our environment. I feel the most urgent problem now is nuclear weapons, power, and waste. I commit myself to continually work on awareness and action dealing with this issue. Enjoy life, keep an open mind, and do the best you can each day!

Paula Holden
Age 33
Winter '81

Wellness can be fully woven into the fabric of community life. . .

I can see the ideas of Wellness becoming integrated in our education - from grade schools to adult education, from teenage programs to Senior Centers - in short, wherever there are groups of people working together.

By becoming an accepted part of our lives, we will learn to take more responsibility for a healthier lifestyle - a more open mind, questioning our doctors, our lawmakers, and our teachers. We will reach a more relaxed state, having learned how to reduce stress, and be more assertive in every day life situations. We will become more concerned

about the state of the world around us and will work to correct what we see is wrong. This will come about with direction from trained leaders who, in turn, will train volunteers to work in communities, churches, AARP groups, Senior Centers, or wherever people want to work for a change in their lifestyle.

Our pilot program in the Wallingford area of Seattle, Washington, has made a significant contribution to the movement that is now sweeping the country. This continuing process is my dream and hope for the future of Wellness.

Jean Newman
Age 72
Fall '80
Wellness Support Group
Advisory Committee Member

"Wellness is for me, and I'm for Wellness". . .

The Wellness Project at Wallingford helped me learn many facts and techniques for physiological, as well as emotional, health. The devoted advocates taught us basic nutrition, assertiveness (not aggressiveness!), environmental awareness, and stress management. With the help of other volunteers, they gave us sessions in several kinds of exercise and in political awareness for senior citizens, also in crime prevention. I hope to share with others the knowledge and techniques I gained.

Charley Solin
Age 70
Winter '81

And finally, a song of celebration. . .

Song of Wellness

I am in control of my life,
I am in control of me.
I am in control of my life,
But God is in control of me.

I must make some changes in my life.
Things that I must learn to do.
I must make some changes in my life,
And that is what I'm going to do.

Changes must be made in my life.
I must learn to live anew.
God is leading me in "New Ways,"
And I can see it coming into view.

Joy and gladness fills my being.
I am being loved...I know!
I am on my way to "Living,"
And I am on my "Way to go."

Flornell A. Marion
Age 73
Winter '81

This collage of participant reactions encompasses many perspectives on what constitutes wellness and a healthy future. Yet, it is important to note that health promotion does not replace the need for basic health care services for older people, and for all people in a free and humane society. Health care is a right, not a privilege. Basic health care should provide a secure foundation, freeing people to learn to take responsibility for maintaining and improving their health by making positive changes in their lifestyles.

Ideally, health promotion should begin in childhood. However, positive "healthstyles" can be developed at any age in order to improve overall health, gain a greater sense of wellbeing, and acquire an ability to be in charge of one's own life. Health promotion programs within a comprehensive health care system can contribute to lowered utilization rates and reduced costs. The ultimate benefit to all of us will be a people healthier in mind, body and spirit, able to maximize our ability to work together to solve problems and work toward global health.

A health care system featuring health promotion can have a significant impact on families, schools, and communities. Such a system requires moving from a strictly medical model toward a more decentralized, community-based educational model for planning and implementing health services.

Finally, as we all grow older, we need to develop the skills and attitudes inherent in the concept of wellness in order to enable us all, individually and collectively, to continue to grow towards realizing the creative potential of full health.

Health Promotion with Older Adults—A Selected Bibliography

James Barrett-DeLong

These references are drawn from the Wallingford Wellness Project's comprehensive bibliography on Health Promotion with the Elderly (see p. vi for reference).

I. HEALTH PROMOTION WITH ELDERS

A. OVERVIEW

1. Richmond, J. Health promotion and disease prevention in old age. Aging, May-June, 1979, 11-15.

In this overview article, demographic data on the 65-and-over population is included, and the areas of "normal" changes that occur with aging, chronic diseases, income factors, social and psychological factors and support services in relation to older adults are addressed.

2. Wells, Thelma. Aging and health promotion. Rockville, MD: Aspen Systems Corp., 1982.

A collection of 19 articles addressing fundamental issues of aging and health.

B. PROGRAMS, EDUCATION AND TRAINING

1. Cox, C. A pilot study: Using the elderly as community health educators. International Journal of Health Education (Geneva), 22(1): 1979, 49-52.

Training elderly persons as "health educators" in Baltimore, Maryland resulted in a core of educators, training curriculum and materials, and numerous requests for similar programs.

2. Luce, G. Your second life: Vitality and growth in middle and later years. New York, NY: Dela Corte Press, Seymour Lawrence, 1979.

Many exercises and techniques used to promote health and vitality in the well known SAGE program are described.

C. POLICY AND PLANNING

1. Estes, C.L. The aging enterprise. San Francisco, CA: Jossey-Bass, Inc., 1979.

The author addresses the status, effectiveness, and social consequences of current public policies and services for the aged, and makes recommendations for developing more realistic and responsible alternative policies and services.

D. RESEARCH AND EVALUATION

1. Rothman, J. Social R & D: Research and development in the human services. Englewood Cliffs, NJ: Prentice-Hall, 1980.

This volume presents a systematic and encompassing set of action guidelines to achieve effective social science program development.

2. Schulberg, H.C., & Baker, F., eds. Program evaluation in the health fields, Vol. II. New York, NY: Human Sciences Press, 1979.

This book is written for both administrators and evaluators involved with managing and assessing health services provided within community-based organizations. Includes 27 papers, 467 pages.

II. HEALTH PROMOTION CONTENT AREAS

A. GENERAL

1. Ardell, D. 14 days to a wellness lifestyle. Mill Valley, CA: Whatever Publications, Inc., 1982.

A simply written, day-by-day wellness strategy with a resource guide to wellness programs in the U.S. and Canada, and an annotated bibliography of wellness books.

2. Farquhar, J.W. The American way of life need not be hazardous to your health. New York, NY: W.W. Norton Publicating Co., 1978.

Dr. Farquhar, director of the Stanford Heart Disease Prevention Program, explains the major cardiovascular risk factors, and provides proven, step-by-step methods to reduce the risks and develop a lifelong pattern of good health.

3. McCamy, J.C., & Presby, J. Human life styling: Keeping whole in the 20th century. New York, NY: Harper & Row, 1975.

Serious illness is both predictable and preventable, according to the authors. They present an approach to health built upon exercise, nutrition, stress management, and ecological action.

B. STRESS MANAGEMENT

1. Girdano, D., & Everly, G. Controlling stress and tension: A holistic approach. Englewood Cliffs, NJ: Prentice Hall, 1979.

Provides an overview of psychophysiological system in relation to stress, a comprehensive classification of stressors and strategies for intervention and management of stress.

2. Pelletier, K.R. Mind as healer, mind as slayer: A holistic approach to preventing stress disorders. New York, NY: Delta, 1977.

A comprehensive description of the body's response to stress. Covers techniques to manage stress, summarizes research. Extensive bibliography.

3. Selye, H. The stress of life. New York, NY: McGraw Hill, 1976 (rev. ed.).

This classic describes what scientists have learned about stress. Reference for people planning to teach stress management.

4. Walker, C.E. Learn to relax - 13 ways to reduce tension. Englewood Cliffs, NJ: Prentice-Hall, 1975.

This is a brief, 108-page "how-to" book geared to the general public. Easy to read and understand.

C. EXERCISE

1. Christensen, A, & Rankin, D. Easy does it yoga - For older people. New York, NY: Harper & Row, 1975.

Valuable resource for beginning wellness practitioners working with older people or people with limited flexibility.

2. Harris, R. Guide to fitness after fifty. New York, NY: Plenum Publications, 1977.

3. Smith, E.C., & Serfoss, R.C., eds. Exercise and aging: The scientific basis. Hillside, NJ: Enslow Publications, 1981.

Twelve technical papers presenting authoritative data and observations on the cardiovascular, musculo-skeletal, respiratory, and other systems of the body, and the principles and limitations of exercise for older people.

D. NUTRITION

1. Hamilton, E.M.N., & Whitney, E.N. Nutrition: Concepts and controversies. St. Paul, MN: West Publications Co., 1979.

This nutrition text presents differing perspectives and principles of nutritional science and guidelines for making food choices. A study guide is available to reinforce concepts.

2. Natow, A.B., & Heslin, J. Geriatric Nutrition. Boston, MA: C.B.I. Publications, Inc., 1980.

Describes the aging process and the relationship of nutrition to this process. Also covers drug interactions, dietary supplements, psychosocial forces, and nutrition education in the later years.

3. Weg, R.B. Nutrition and the later years. Los Angeles, CA: University of Southern California Press, The Ethel Percy Andrus Gerontology Center, 1978.

Describes changing nutritional requirements in the elderly, discusses nutritional adequacy, metabolic and digestive function changes related to aging, and effects of diet on pathologies and vice versa.

E. INDIVIDUAL, INTERPERSONAL AND SOCIAL CHANGE SKILLS

1. Alberti, R.E., & Emmons, M.L. Your perfect right. San Luis Obispo, CA: Impact, 1978 (3rd ed.).

Classic step-by-step program to develop assertive behavior. Includes a section for trainers and a discussion of applications.

2. Coover, V., Deacon, E., Esser, C., & Moore, C. Resource manual for a living revolution. Philadelphia, PA: New Society Press, 1977.

This manual teaches a process enabling people working together to assume leadership and make environmental changes so that human needs can be more adequately met. Skills taught include managing and resolving social and interpersonal conflicts creatively.

3. Freudenberg, N. Change to social change. Health Education Monographs., 6(4): 372-377, Winter, 1978.

The drawbacks of health education directed toward individual behavior change and the rationale, goals, and some methods of implementing health education for social change are discussed.

F. ENVIRONMENTAL ISSUES AND ADVOCACY

1. Barnet, R.J. The world's resources. The New Yorker, March 17, 31; April 7, 1980.

These articles analyze the ecology, depletion, and misuse of the world's resources.

2. Caldicott, H. Nuclear Madness. Brookline, MA: Autumn Press, 1978.

This primer provides information about nuclear hazards and what people can do to reduce the risk of nuclear war.

3. Scherer, D. Personal values and environmental issues. New York, NY: Hart Publications Co., 1978.

A handbook of strategies and experiential techniques related to the environmental issues of pollution, energy, food, population, and land use.

III. RELATED TOPICS

A. VOLUNTEERISM

1. Naylor, H.H. Volunteers today-finding, training, and working with them. Dryden, NY: Dryden Associates, 1973.

Written for people in leadership positions in organizations requiring volunteer work. This book describes how to increase both the effectiveness and satisfaction of volunteers.

2. Wilson, M. The effective management of volunteer programs. Boulder, CO: Johnson Publications Co., 1976.

A comprehensive and leading text on managing volunteer programs.

B. SUPPORT NETWORKS

1. Collins, A.H., & Pancoast, D.L. Natural helping networks: A strategy for prevention. Washington, D.C.: National Association of Social Workers, 1976.

2. Petty, B.J., Moeller, T.P., & Campbell, R.Z. Support groups for elderly persons in the community. The Gerontologist, 15(6), 1976.

Presents techniques used in four community-based support groups for elderly persons experiencing moderate stress as a result of the aging process.

C. PARTICIPATORY LEARNING MODEL

1. Knowles, M., & Knowles, H. Introduction to group dynamics. New York, NY: Association Press, 1972.

This book is a theory-and-practice introduction for anyone interested in basic group dynamics.

2. Rose, S.D. Group therapy: A behavioral approach. Englewood Cliffs, NJ: Prentice-Hall, 1977.

Covers group beginnings, assessment, evaluation and research, goal setting, reinforcement and contracting, modeling and behavior rehearsal, modifying group interaction, and group endings. Applications include assertive training and communication skills workshops.

3. Benne, K.D., Bradford, L.P., Gibb, J.R., Lippitt, R.O., eds. The laboratory method of changing and learning. Palo Alto, CA: Science and Behavior Books, Inc., 1975.

Reference book for understanding and applying group methods.

D. TEAM MANAGEMENT

1. Crow, V., Riddle, D., & Sparks, C. Critique and commentary - The process/product debate. Quest, 4(4), Fall 1978, 15-36.

These three articles provide a variety of perspectives regarding the relationship of process and product in groups and organizations.

2. Hooyman, N. Redefining models of power and administrative style. Social Development Issues, 2(3), Winter 1978, 46-53.

Highlights values and strengths women can bring to management to help create new models for administration.

3. Kanter, R.M. Evaluating alternatives and alternative valuing. The Journal of Applied Behavioral Science, 9(2/3), 1973, 381-397.

Article discusses a new set of criteria for evaluating alternative institutions, institutions which are themselves predictive of alternatives which might become functionally dominant in society.

APPENDICES

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APPENDIX A

ENVIRONMENTAL ASSERTIVENESS
Sample Program Outline

PHASE I

Week 1: Introductions to people and the program. Risk factor analysis sheet.

Week 2: Introduction to communication skills and assertiveness.

Week 3: Communications skills and assertiveness.

Week 4: Communications skills and assertiveness.

Week 5: Communications skills and assertiveness.

Week 6: Discussion on environmental issues, choosing environmental topics class is interested in learning more about.

Week 7: Evaluations, assessment of participation forms, discussion on how different areas of the program work together and how to maintain change.

PHASE II

Week 1: Environmental topic.

Week 2: Discussion on environmental topic.

Week 3: Environmental topic.

Week 4: Discussion on environmental topic.

Week 5: Discussion on making and maintaining change.

Week 6: Review of communications skills and assertiveness. Environmental topic.

Week 7: Evaluations, assessment of participation forms. Discussion on environmental topic.

PHASE III

Week 1: Environmental topic.

Week 2: Discussion on environmental topic.

Week 3: Environmental topic.

Week 4: Discussion on environmental topic.

Week 5: Review of communications skills and assertiveness. Discussion on making and maintaining change.

Week 6: Endings, where do we go from here?

Week 7: Evaluations, assessment of participation forms. Review of our learning. Celebration!

APPENDIX B

EXERCISE

Sample Program Outline

Week 1: Introduction, benefits of exercise, review of workbook, self-assessment of fitness level, beginning stretching exercises, exercise survey.

Week 2: Review the past week, finalizing outline, aerobic exercise discussion, practice pulse taking, McCamy's movements.

Week 3: Review past week, focus on stretching exercises.

Week 4: Review, physiology of aging talk, aerobic dancing.

Week 5: Review, low back session, stretching exercises.

Week 6: Review, aerobic dancing, yoga.

Week 7: Review, Tai Chi or yoga, maintaining change, evaluation, log.

APPENDIX C

NUTRITION

Sample Program Outline

Week 1: Introduction, overview of good dietary guidelines, cooking demonstration, review of workbook, explanation of self-assessment forms.

Week 2: Breakfast, discussion of labels, what's so bad about high sugar diets?

Week 3: Lunch, what's wrong with fast foods?, why not fat?

Week 4: Dinner, focus on complementary proteins, complex carbohydrates.

Week 5: Snacks, facts about salt and ways to reduce sodium intake, facts about cheese, eating out.

Week 6: Menu planning, ways to make substitutions in recipes, food preservation.

Week 7: Wrapup, potluck meal, evaluation.

APPENDIX D

STRESS MANAGEMENT

Sample Program Outline

Week 1: Introduction and planning; shoulder and neck massage.

Week 2: Overview of stress; deep breathing.

Week 3: Overview of stress; counting breaths.

Week 4: Twelve mental steps; counting breaths.

Week 5: Biofeedback; progressive relaxation.

Week 6: Time management; progressive relaxation.

Week 7: Meditation; instant relaxation drill.

APPENDIX E

WALLINGFORD WELLNESS PROJECT CLASS SCHEDULE

As a participant in the Wallingford Wellness Project, we hope you will be actively involved in all four classes:

- Stress Management
- Nutrition
- Environmental Assertiveness
- Exercise

*One of the classes, Environmental Assertiveness, lasts the entire 21 weeks.

*The other three classes--Nutrition, Stress Management, and Exercise--last seven weeks each.

Below is an example of a schedule:

(7 Weeks)	(7 Weeks)	(7 Weeks)
Stress Management /	Exercise /	Nutrition
(21 Weeks----------		)
---------Environmental Assertiveness---------		

For 21 weeks of classes you would come to the Senior Center once each week for 3 hours.

At the end of this workshop, you will be choosing <u>one</u> group in which you will participate.

In choosing your class, consider both the blocks of time you have available and the content area which you want to start with. This workshop will help you decide which content area you want to explore first.

APPENDIX F

SAMPLE AGENDA

Cohort III, Monday Group
Stress Management Class #2
Date: August 31, 1981, 9-10:25 a.m.
Class Coordinator: Sue

Time	What	Who
9:00	Massage review	James
9:07	Reportbacks	Jean
9:15	AAA (Attendance, Agenda, Announcements)	Sue
9:20	Biofeedback presentation	Jo Jones (School of Nursing, UW)
9:50	Body scan/change of pace break	Jean
10:00	Deep breathing	James
10:10	Tension logs	Jean
10:20	Reminders & next week: -practice -keep logs	Sue
10:25	-foot massage	

85 min. total

Program Arrangements: Sue

Set up: flip chart - James/Jean/Sue
scrapbook
stress booklets
logs - Jean

Announcements: library books & scrapbook
circulate stress booklets

(APPENDIX F CONTINUED):

EXPLANATION OF SAMPLE AGENDA

The identifying information at the top is used for reference and filing purposes. The class coordinator has bottom line responsibility for the class. The time provides a guideline; the running time allows facilitators to know at a glance if they are on schedule. Staff recommends flexibility of time allotment, use of a timekeeper, and allowing five minutes slack time.

In the What category, the review and reportbacks focus the group and provide continuity with previous sessions. During reportbacks participants share progress and do problem solving around difficulties. The three A's include taking attendance, reviewing the session's agenda, and allowing time for participants and staff to announce relevant items.

The presentation by staff, outside resource person, or class member, provides the new material of the session. Whenever possible it includes an experiential component and a discussion of how to apply the new knowledge. The break is used to model what we teach: stretching, getting fresh air, sharing healthy food or drink, and socializing are familiar break activities. Deep breathing is an example of an experiential exercise where participants may feel immediate benefits and facilitators may observe, instruct, and correct new learnings.

Standard activities to end sessions are working with logs, surveys, or Affirmations of Health, when participants decide how they will integrate the day's learnings into their daily lives. They may write their plan down, share it in small groups, or announce it to the entire class. These tools strengthen follow-through behavior. Reminders and next week serve to tie together the session's purposes and encourage anticipation of the following week's activities. Classes sometimes end with an evaluation of the class.

The Who column clarifies responsibility for segments that are self-selected by the facilitators. Program arrangements designates who will secure the main presentor (usually done 2-3 weeks in advance when possible). Participants often help with set up tasks. When group sessions are planned ahead the announcement section may be filled in later, as the class date approaches.

APPENDIX G

ONE WEEK ASSERTIVE RESPONSES SURVEY

Name _____ Date Survey Started _____

For each day in the following week, please briefly describe the situations in which you were assertive (A. Situation) and what you said and did in those situations (B. Action Taken). It is important that you try to list all situations in which you believe you behaved assertively. This may be easiest to do if you record the situations and your responses as they occur throughout the day. If this is not possible, take time at the end of each day to fill out the form for that day.

ASSERTIVE RESPONSES

A. SITUATION (Describe briefly the situation)	B. ACTION TAKEN (What you said and did)
EXAMPLE:	
"SOMEDAY"	
1. Returning a new dress with faulty seams to the store.	1. Asked for my money back. Showed receipt. Got money back.
MONDAY	
TUESDAY	

(continued for the rest of the week)

APPENDIX H

DAILY STRESS AND TENSION LOG

Name _____

Day of Week	Date and Time of Day	Stressful Event (Stressor)	My Physical Response	Thoughts and Feelings I Experienced	What I Did
MONDAY					
TUESDAY					
WEDNESDAY					
THURSDAY					
FRIDAY					
SATURDAY					
SUNDAY					

APPENDIX I

ONE WEEK PHYSICAL ACTIVITY SURVEY

NAME _____

DATE SURVEY STARTED _____

For each day in the following week, please record the type, duration and frequency of all your physical activities. There are many different types of physical activities, and it is important that you list all types. For example, some activities are quite strenuous and increase your heart rate (e.g., running, swimming, racket sports, dancing). Others are not as strenuous but increase muscle flexibility and body control (e.g., yoga, stretching, Tai Chi). A third type of physical activity increases strength and stamina (e.g., weight lifting and isometric exercises). Other examples of activities are bicycling, stationary bicycling, water exercise, swimming, jumping rope, gardening, walking, and jogging. You may engage in other physical activities, too, which you should list.

Under the column labelled "Type of Activity," list all your physical activities for each day of the next week. Under the column labelled "Total Time Spend," record the total time spent that day doing the activity. Under the column labelled "Number of Times," indicate the number of times you engaged in the activity during that day. Some of you might walk 20 minutes in the morning and 30 minutes in the afternoon. If this applies to you, you would list walking under "Type of Activity," 50 minutes under "Total Time Spent," and 2 under "Number of Times." If you take your pulse rate immediately after each activity, please record this under the column labelled "Pulse Rate." If you don't take your pulse, leave it blank.

ONE WEEK PHYSICAL ACTIVITY SURVEY
PAGE TWO

NAME _____

EXAMPLE:

	Type of Activity	Total Time Spent	Number of Times	Pulse Rate
"SOMEDAY"	stretching	15 mins.	1	80
	yardwork	45 mins.	2	
"ANOTHERDAY"				
	stretching	10 mins.	1	80
	jogging	20 mins.	2	110
MONDAY				
TUESDAY				

(continued for the rest of the week)

APPENDIX J

ONE DAY DIET SURVEY

DATE _____

NAME _____

Please list all the food and drink, including seasonings and condiments, you consume on the above date. Estimate the quantities. (For example--one medium sized hamburger, ½ cup peas, 1T butter, catsup, 2 pinches salt, 1 cup Liptons tea, 3 carrot sticks, 1 piece chocolate cake, 3" square).

BREAKFAST:

_____

_____

_____

LUNCH:

_____

_____

_____

DINNER:

_____

_____

_____

SNACKS (THROUGHOUT THE DAY):

_____

_____

_____

APPENDIX K

From The Outlook, July 30, 1980.

"Wallingford Wellness Project
Making health a lifestyle"

by Kris Freeman

The Wallingford Wellness Project tries to help people experience health in new, positive ways, according to Molly Mettler.

"Wellness is more than just the absence of disease," said the project staff member.

About 60 Wallingford residents, adolescents to octogenarians in range of age, enlisted this spring in the health promotion and research program. For the past several months they've been in search of "wellness" at weekly workshops held at the Good Shepherd Center.

The Wallingford Senior Center, University of Washington School of Social Work and Senior Services and Centers are all involved in the project paid for with a $137,000 federal grant.

The research part of the project is concerned with the possible benefits of health education for senior citizens, who typically are regarded from an illness-oriented perspective focusing on specific problems like cardiovascular disease. Because of Wallingford's high population of seniors and proximity to the UW, the district was chosen as the area to conduct the Project.

The emphasis of the workshops is not merely on dispensing information about nutrition and exercise, but on helping people to integrate that knowledge into the way they live.

Class members sample tofu mayonaise, devise aerobic exercise schedules and learn yoga to combat stress.

Project staff contend that all these areas have direct influence on health. "If you eat badly, you feel badly," said Mettler.

Environmental issues, ranging from the incident at Three Mile Island to the feasibility of installing heat pumps to save energy are also discussed. The staff reasons that if you breathe polluted air while you jog the exercise won't do as

much good as it could. This is part of their broad view of health which considers the effects of a person's social and physical environment on their wellbeing.

Despite the unifying philosophy of the program, there isn't pressure for everyone to conform to what is promoted as healthy. "We're not trying to convert people suddenly from meat and potatoes to bean sprouts and tofu," said Mettler. Rather the goal is to help people make the lifestyle changes that they want, she explained.

In this process, project staff see themselves more as consultants than instructors. Participants are free to share their knowledge with each other (one woman leads a class in Tai Chi) and have begun to organize activities on their own.

"It's our goal to develop leaders so that the program continues after we're gone," said James Barrett-DeLong, another staff member. "If we didn't do that, we haven't done our job."

So far the response from class members has been enthusiastic. "I'd highly recommend the program," said Vera Miller, pleased to discover that her blood pressure dropped during the course of the exercise classes.

Several other wellness seekers testify that relaxation techniques learned in the stress management workshops have helped them to sleep. One delighted mother found that her seventh grader enrolled in the program is, at last, eating less junk food.

Another woman had been injured in a fall within weeks of being robbed. Discouraged, she considered selling her house. The class discussed ways that she could stay in her home and neighborhood, such as taking advantage of programs that provide household help and aired their own fears and frustrations about changes in their lives as they grew older.

"It's important for them to support each other and not to make decisions out of isolation or in ignorance of services they can use to stay healthy and stay in their environment," said Barrett-DeLong.

A class member put it a different way. "You'd be amazed at all the caring that goes on in a small group like this."

Classmates meet regularly to walk or swim together and express interest in starting discussion groups, a daily exercise class and food buying club.

"There can be a major difference between knowing how to be healthy and living a healthy life," noted Barrett-DeLong. "We help people to live that healthy life."

The next 24-week session of workshops will begin in October. There will be space in the weekly workshops for 125 Wallingford residents from age 15 through 105. Tuition is free.

The project is also looking for 125 senior citizens to serve as members of a comparison group. The information they'll provide through interviews and blood tests will provide the contrast necessary for valid research.

For more information or to register call 447-7825 or 447-7821 Monday through Thursday, or stop by the Good Shepherd Center at 4649 Sunnyside Ave., N.

APPENDIX L

WELLNESS SUPPORT GROUP
EVALUATION QUESTIONNAIRE

This evaluation is designed to find out how effective the Support Group has been in working towards the following goals: (1) to create a group of people who provide support to each other; (2) to help maintain and develop positive health behaviors; (3) to encourage you to be in control of your lives and actions; (4) to establish a group of people who have the skills and enthusiasm to help conduct an ongoing wellness program. The information provided by this evaluation will help us all plan the Support Group so it can best meet your needs. Thanks for your thoughts.

I. For each of the following statements please indicate whether the statement lists things which have been very helpful, helpful, or least helpful by checking the appropriate space.

The Support Group has:	Very Helpful	Helpful	Least Helpful
A. Helped me to be more self-confident	_____	_____	_____
B. Provided me with a supportive community	_____	_____	_____
C. Helped me to be more assertive and confident in saying and doing what I think is best	_____	_____	_____
D. Provided me with skills to communicate and share information with others	_____	_____	_____
E. Helped me make new friends	_____	_____	_____
F. Helped me to maintain positive health behaviors	_____	_____	_____
G. Provided me with skills to plan activities	_____	_____	_____
H. Helped me to start new positive health behaviors	_____	_____	_____
I. Other (please explain)	_____		

_____

_____

(APPENDIX L CONTINUED)

2. For each of the following activities indicate whether the activity has been very helpful, helpful, or least helpful for you in maintaining positive health behaviors.

		Very Helpful	Helpful	Least Helpful
A.	Weekly exercises	_____	_____	_____
B.	Speakers	_____	_____	_____
C.	Health style brags	_____	_____	_____
D.	Ongoing skill development (for example--facilitating part of a meeting)	_____	_____	_____
E.	Skill development workshops	_____	_____	_____
F.	Planning	_____	_____	_____
G.	Catchup	_____	_____	_____
H.	Informal socialization	_____	_____	_____
I.	Group discussion	_____	_____	_____
J.	Other (please explain)	_____		

_____

_____

3. Which of the following activities has helped provide you with abilities to conduct and maintain an ongoing wellness program once the existing staff are gone? (Check as many as appropriate.)

___ Weekly Exercises ___ Speakers ___ Healthstyle brags
___ Catchup ___ Ongoing skill development
___ Skill Development Workshops ___ Planning
___ Informal Socialization ___ Group Discussion
___ Other (please explain) _____

_____

4. Which of the following activities have helped you to be more confident and assertive in saying and doing what you think is best? (Check as many as appropriate.)

___ Weekly Exercises ___ Speakers ___ Healthstyle brags
___ Catchup ___ Ongoing skill development
___ Skill Development Workshops ___ Planning
___ Informal Socialization ___ Group Discussion
___ Other (please explain) _____

_____

(APPENDIX L CONTINUED)

5. Which of the following activities has provided you with support from other group members? (Check as many as appropriate.)

___ Weekly Exercises ___ Speakers ___ Healthstyle brags
___ Catchup ___ Ongoing skill development
___ Skill Development Workshops ___ Planning
___ Informal Socialization ___ Group Discussion
___ Other (please explain) _____

_____

6. Did you participate in the skill development workshops?

_____ yes _____ no

If you answered yes to #6, please answer #7:

7. The information provided in the workshops was: (Check as many as appropriate.)

___ New to me
___ Already familiar to me
___ Useful for me
___ Not very useful
___ Other (please explain) _____

_____

If you answered no to #6, please answer #8: (Check as many as appropriate.)

8. I didn't attend the workshops because:

___ I am not interested in the information
___ I had other plans those days
___ Other (please explain) _____

_____

9. Have you participated in helping to conduct the Support Group meetings or activities? (For example--facilitating part of a meeting, arranging for speakers, leading exercises, etc.)

_____ yes _____ no

10. Have you shared information from the Support Group with your family, friends, and/or community?

_____ yes _____ no

11. Would you be interested in helping plan and facilitate a Support Group for the second group of wellness program graduates?

_____ yes _____ no

If you answered yes to #11, do you feel prepared to help plan and facilitate a Support Group? _____ yes _____ no

If not, what additional skill training would you like?

_____

_____

_____

12. Has the Support Group provided support to you which you would not have if the Support Group did not exist?

_____ yes _____ no

13. Two things we could do to improve the Support Group are:

_____

_____

_____

_____

_____

14. The thing I enjoy the most about the Support Group is:

_____

_____

_____

APPENDIX M

Wellness Advocate _____ Section _____ Phase _____
Date _____ Subject _____

WELLNESS ADVOCATE EVALUATION FORM

Instructions: Please use this evaluation as a way of improving your own teaching and to help us know where we can be of assistance.

1. I like it when I: _____

_____

2. Some things I would do to improve the class are: _____

_____

3. Since teaching this class, my own healthstyle has improved in the following ways: _____

4. The most important insights I have gained from teaching this class include:

_____

_____

5. Do you feel committed to teaching health promotion at least part-time over the next year? YES _____ NO _____ DON'T KNOW _____

Instructions: Please rate your own ability in the following skill areas on a scale of 1-19, 1 being "lacking skill" and 10 being "very skillful." Circle the appropriate number.

	LACKING SKILL									VERY SKILLFUL
1. Ability to listen well and respond appropriately.	1	2	3	4	5	6	7	8	9	10
2. Ability to speak clearly.	1	2	3	4	5	6	7	8	9	10
3. Ability to get the class involved.	1	2	3	4	5	6	7	8	9	10
4. Ability to respond constructively to conflict or confusion.	1	2	3	4	5	6	7	8	9	10
5. Ability to keep the class on track.	1	2	3	4	5	6	7	8	9	10
6. Ability to plan and organize the class session.	1	2	3	4	5	6	7	8	9	10
7. Understanding of the subject matter.	1	2	3	4	5	6	7	8	9	10
8. Ability to clearly explain the subject matter.	1	2	3	4	5	6	7	8	9	10
9. Sensitivity to what it's like to get older.	1	2	3	4	5	6	7	8	9	10
10. Helping class participants to make and maintain positive health changes.	1	2	3	4	5	6	7	8	9	10

OTHER COMMENTS: Please use the back of this sheet to describe in greater detail specific problems or successes you have had in any of the skill areas 1 - 10. Please give examples and refer to the number of the skill area above.

APPENDIX N

JOB DESCRIPTION
WALLINGFORD WELLNESS DEMONSTRATION PROJECT

Position: Health Educator/Social Worker

Results: Program activities are developed, implemented and evaluated. Research interviews and tasks are carried out. Project information is organized and disseminated to other professionals. The second cohort recruited, the media is kept informed of our activities. A social work practicum student is supervised.

Responsibilities:

A. Staff team functions: (25%)
   1. Implement team tasks as determined by the team according to skills and project needs;
   2. Coordinate tasks as determined by team;
   3. Facilitate and take notes at team meetings on a rotating basis.

B. Teacher/facilitator: (40%)
   1. Organize, coordinate and conduct workshops;
   2. Develop and teach program materials in health education;
   3. Supervise social work practicum student;
   4. Develop and teach peer counseling (as time permits).

C. Direct service social work functions: (10%)
   1. Provide time-limited individual and intergenerational family counseling, when appropriate;
   2. Provide social service brokerage function for participants;
   3. Develop and implement social and recreational components of the program.

D. Research functions: (10%) Assist the Research Assistant with data collection and other research activities.

E. Community relations and information dissemination: (15%)
   1. Keep the media informed of Project activities;
   2. Speak to community groups, churches, other health care organisations about the Project;
   3. Disseminate Project information to other health care professionals.

Qualifications:

A. One year experience teaching health education classes.
B. Two years experience teaching and leading groups.
C. Demonstrated expertise in communication and interviewing skills.
D. One year supervisory experience.
E. Ability to work under pressure.
F. Experience with and understanding of wellness principles.
G. One year experience working with the elderly.
H. Commitment to participatory decision making and a team model.

I have read my job description and agree to the terms and conditions as described herein.

Signature _____ Date _____

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APPENDIX O

JOB DESCRIPTION
WALLINGFORD WELLNESS DEMONSTRATION PROJECT

Position: Coordinator

Results: Efficient intra-staff communication. Efficient communication between Team and key people outside the team. Smooth administrative functioning. Efficient practicum instruction. Accomplishment of educational objectives in areas determined by Staff Team.

Responsibilities:

A. Intra-staff liaison. Responsible for determining need for coordination on various tasks and projects and for ongoing, overall intra-staff coordination. (15%)
B. Coordination and liaison between Team and Steering Committee. (2.5%)
C. Coordinating practicum work. (2.5%)
D. Coordination and liaison between Team and Principal Investigators and Project Director. (10%)
E. Coordination and liaison between Team and Senior Center Director and Staff. (2.5%)
F. Staffing Advisory Committee. (2.5%)
G. Administrative details. i.e., personnel policies, coordinating preparation of certain reports, coordinating staff work on grants, etc. (30%)
H. Staff Team functions as determined by the Team. (10%)
I. Facilitate/teach workshops and classes as determined by the Team. (30%)

Note: Other staff members will assume responsibility for coordinating specific projects as determined by the Staff Team. They will establish linkages with the key figures above and with community people, as necessary to carry out their work. However, it is important that staff members share information in a timely manner with other staff and especially with the Coordinator. This will make coordination easier and will assure that the Coordinator has an overall grasp of Team activities.

Qualifications:

A. MSW
B. Three years experience in an administrative capacity including supervision, coordination, planning, budget development, and program evaluation.
C. Two years experience in group facilitation and teaching.
D. One year experience with a Team approach to management.
E. One year experience working with the elderly.
F. Commitment to collective decision making.
G. Understanding of the basic concepts of wellness.

I have read my job description and agree to the terms and conditions as described herein.

Signature _____ Date _____

APPENDIX P

JOB DESCRIPTION
WALLINGFORD WELLNESS PROJECT

Position: Health Promotion Specialist

Results: Provision of programs and information in any of the four content areas as determined by the Team. Facilitation/support of lifestyle changes for participants. Assistance in provision of data base for research component of Project. Efficient coordination of Team assigned tasks. Development and coordination of long-range planning and program planning.

Responsibilities: (Percentages on each will vary according to self-selection by each staff person from the following.)

A. Data collection and participation in research effort.
B. Development of materials; planning, preparation and facilitation of classes and workshops in any of the four content areas.
C. Planning/coordination of tasks as determined by the Team (such as recruitment and program design).
D. Long-range planning and assistance with administrative tasks and coordination.
E. Information gathering and dissemination, community liaison and public relations.
F. Collective responsibility, with the rest of the Staff Team, for ensuring that the short and long-term goals of the Project will be met in a cooperative and expeditious manner.

Qualifications:

A. One year experience teaching and facilitating health promotion classes.
B. Demonstrated expertise in communication and interviewing skills.
C. One year experience in information gathering and dissemination to service providers and the press.
D. One year experience in planning and coordinating social service programs.
E. Ability to work under pressure.
F. Experience with and understanding of wellness principles.
G. Master's degree in Social Welfare, Health Education, Nursing or related field or equivalent education and experience combined.
H. One year experience working with older persons.
I. Commitment to participatory decision making and a Team model.

I have read my job description and agree to the terms and conditions as described herein.

_____ _____
Signature Date